



Protecting, Maintaining and Improving the Health of All Minnesotans

*****Please Note that Health and Life Safety Code (LSC) surveys are being processed in separate cycles. This letter is for the Health survey. *****

Electronically delivered

September 24, 2025

Administrator
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE
333 FIFTH STREET WEST
WACONIA, MN 55387

RE: CCN: 245234

Cycle Start Date: May 27, 2025

Dear Administrator:

On June 20, 2025, we notified you a remedy was imposed. On July 14, 2025, the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of 07/04/2025.

As authorized by CMS the remedy of:

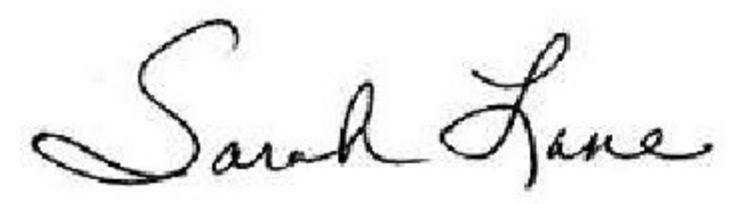
- Discretionary denial of payment for new Medicare and Medicaid admissions effective 07/05/2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 20, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 5, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on 07/04/2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

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



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Electronically delivered

September 24, 2025

Administrator
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE
333 FIFTH STREET WEST
WACONIA, MN 55387

Re: Reinspection Results
Event ID: GM9012

Dear Administrator:

On 07/14/2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on 05/27/2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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

Email: sarah.lane@state.mn.us

An equal opportunity employer.



Protecting, Maintaining and Improving the Health of All Minnesotans

*****Please Note that Health and Life Safety Code (LSC) surveys are being processed in separate cycles. This letter is for the Life Safety Code survey.*****

Electronically Delivered
September 24, 2025

Administrator
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE
333 FIFTH STREET WEST
WACONIA, MN 55387

RE: CCN: 245234
Cycle Start Date: May 19, 2025

Dear Administrator:

On August 12, 2025, the Minnesota Department of Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
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*****PLEASE NOTE THAT THE HEALTH AND LIFE SAFETY CODE (LSC) SURVEYS ARE BEING PROCESSED IN SEPARATE ENFORCEMENT CYCLES. THIS LETTER IS FOR THE HEALTH SURVEY.*****

Electronically delivered

June 20, 2025

Administrator

Good Samaritan Society - Waconia And Westview Acre

333 Fifth Street West

Waconia, MN 55387

RE: CCN: 245234

Cycle Start Date: May 27, 2025

Dear Administrator:

On May 27, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 5, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 5, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 5, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

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

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by July 5, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Waconia And Westview Acre will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 5, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

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.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 27, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40,

et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity

assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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

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.

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

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

PRINTED: 07/09/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/27/2025
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE			STREET ADDRESS, CITY, STATE, ZIP CODE 333 FIFTH STREET WEST WACONIA, MN 55387		
(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
E 000	Initial Comments	E 000			
	On 5/18/25 to 5/27/25, 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 5/18/25 to 5/27/25, 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. : H52344769C (MN00109631). H52344768C (MN00110477). The following complaints were reviewed: H52344068C (MN00112807) with a deficiency cited at (F686). H52344767C (MN00111524) with a deficiency cited at (F628). H52344010C(MN00112769) (MN00112536) with a deficiency cited at (F628). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/30/2025

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

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F 000	Continued From page 1 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.	F 000			
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility	F 604			7/4/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/27/2025
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F 604	Continued From page 2 must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pillows were not used in a manner to restrain residents while in bed for 1 of 1 resident (R21) reviewed for restraints. Findings include: R21's admission Minimum Data Set (MDS) dated 3/23/25, identified R21 had moderate cognitive impairment and diagnoses of dementia, Parkinson's, seizure disorder and depression. MDS also indicated R21 did not use any restraints. R21's care plan reviewed 5/27/25, identified R21 had limited physical mobility and was a fall risk related to confusion and restlessness. Staff were directed to assist R21 from lying to sitting and from sitting to lying with an assist of one to help guide lower extremities and to assist R21 with an assist of two for sit to stand for all transfer. R21 used a fall mat next to his bed. R21's care plan did not identify the use of pillows under his fitted sheet to prevent R21 from crawling out of bed. During an observation on 5/18/25 at 5:20 p.m., R21 was lying on his back in the middle of his bed with his blankets covering to his chest. On R21's right side two pillows were tucked under the fitted sheet and ran along R21's body from his shoulders to his knees. R21's bed was in low position with a fall mat next to his bed.	F 604	F604 The Right to be Free from Physical Restraints 1. On 5/27/25 Clinical Care Leader verified the use of pillows tucked in sheets for R21 was ceased. 2. DNS or Designee completed Resident round/audit performing resident observation assessing for equipment or devices restricting physical mobility of residents on 5/27/25 to identify any residents that have the potential to be affected by deficient practice. No other residents were found to have pillows or other devices used in a manner to restrain resident's mobility. 3. To ensure deficient practice will not recur, all nursing staff and leadership staff will be educated by 7/4/25 or prior to next working shift using Physical Restraints/Psychotropic Medication Alternatives and Resident Rights Policy and Procedure. Staff will be educated on alternative methods of care avoiding using devices to restrict resident mobility. Facility will initiate Angel Rounds by 7/4/25 utilizing leadership in all resident care areas during business days. Angel Rounds will include a review of potential equipment restricting resident movements with any concerns corrected immediately and findings reporting in leadership meeting.		

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F 604	Continued From page 3 During an observation on 5/19/25 at 3:07 p.m., R21 was lying on his back in the middle of his bed with his blankets covering to his chest. On R21's right side two pillows were tucked under the fitted sheet and ran along R21's body from his shoulders to his knees. R21's bed was in low position with a fall mat next to his bed. During an observation on 5/20/25 4:49 a.m., R21 was lying on his back in the middle of his bed with his blankets covering to his chest. On R21's right side two pillows were tucked under the fitted sheet and ran along R21's body from his shoulders to his knees. R21's bed was in low position with a fall mat next to his bed. During an observation on 5/20/25 8:15 a.m., R21 was lying on his back in the middle of his bed with his blankets covering to his chest. R21's eyes were open with him looking around his room. On R21's right side two pillows were tucked under the fitted sheet and ran along R21's body from his shoulders to his knees. R21's bed was in low position with a fall mat next to his bed. During interview on 5/20/25 at 5:21 a.m., registered nurse (RN)-F stated R21 did not like to get up and that he needed assistance to get out of bed. RN-F stated R21 was a fall risk and that was the reason why the pillow was tucked in under the bottom sheet that ran along R21's body. RN-F stated the pillow stops him from getting out of the bed, the pillows have been used for "awhile". During interview on 5/20/25 at 12:55 p.m., trained medication aide (TMA)-A stated R21 attempted to get out of bed by himself. TMA-A stated R21's pillows were underneath the fitted sheet so R21	F 604	4. To monitor performance and ensure on going compliance, DNS or designee will audit 20% of resident population weekly x 4 week, monthly x 2 assessing for equipment or devices restricting physical mobility of residents by observation. Angel Rounds concerns will be reviewed in morning leadership meeting to discuss any concerns noted related to equipment or devices restricting physical mobility of residents. The results of those audit findings will be brought to the QAPI Committee meeting by the DNS or designee for further recommendations. 5. Substantial compliance will be achieved by 7/4/25.		

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F 604	Continued From page 4 could not get out of bed, "we do it all the time." TMA-A stated she did not know if R21 could remove the pillows if R21 wanted to. During interview on 5/20/25 at 1:04 p.m., nursing assistant (NA)-F stated R21 was a fall risk and a pillow was placed along his right side at all times so R21 couldn't get out of bed. NA-F stated she did not know if R21 could remove the pillows if R21 wanted to. During interview on 5/27/25 at 3:55 pm., RN-A stated resident could not get out of bed by himself and staff have to assist him with transfers. RN-A stated R21 liked to sit up on the edge of the bed but was not strong enough to stand up. RN-A confirmed there was no physical restraint assessment completed for R21 as she was not aware of staff utilizing pillows along R21's side. RN-A stated pillows should not be placed under the sheet as it could be considered a restraint. RN-A stated she would have to assess R21 to see if he could remove the pillow by himself. RN-A stated she would expect staff to update her if they are utilizing pillows in this manner. The facility Restraints policy, dated 10/29/24, indicated resident are free from any physical or chemical restrains imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. When the use of restraints is indicated, the location must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Anytime a device, material or equipment is attached or placed adjacent to the resident's body, a determination will be made by a licensed nurse as to whether it is or could be a restrain for the			F 604			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 604	Continued From page 5	F 604			
F 605 SS=D	individual resident and a Physical Device and/or Restraint Evaluation and Review is completed by a licensed nurse. Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 605			7/1/25

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F 605	Continued From page 6 but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 605			

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F 605	Continued From page 7 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure pharmacy consultant (PharmD) gradual dose reduction (GDR) recommendation was communicated to the Hospice prescriber for 1 of 5 residents (R43) reviewed for unnecessary medications. Findings include: In review of R43's Order Summary Report (print date 5/27/25) indicated the diagnoses of: dementia, visual hallucinations, psychotic disturbance, mood disturbance and anxiety. R43's quarterly Minimum Data Set (MDS), dated 4/17/25, identified R43 had severely cognitive impairment.	F 605	The Right to be Free from Chemical Restraints 1. On 5/21/25 the pharmacy consultant's recommendations were immediately communicated for R43 antipsychotic medication to the hospice prescriber. Verbal order was implemented on 5/28/25, per hospice provider's recommendations. 2. Any hospice resident with pharmacy recommendations have the potential to be affected by deficient practice. By 7/4/25 review of all hospice residents pharmacy recommendations for the last 90 days, regarding psychotropic medications were reviewed ensuring communication to		

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F 605	Continued From page 8 R43 was admitted to Allina Hospice with the diagnosis of vascular dementia [due to] CVA (cerebral vascular accident - stroke) on 1/29/25, with the orders to use hospice agency standing orders. In review of R43's Order Recap Report (printed 5/20/25) resident was and is receiving Quetiapine Fumarate (and anti-psychotic medication with the following order changes: The following orders were prescribed on the dates indicated to the facility: 3/26/25 Quetiapine Fumarate Oral Tablet 50 milligrams (mg) (Quetiapine Fumarate) Give 100 mg by mouth every 6 hours as needed for agitation or hallucinations. AND Give 50 mg by mouth two times a day for agitation, hallucinations 4/1/25 Quetiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate) Give 25 mg by mouth two times a day for agitation, hallucinations Administer with 50mg. A review of R43's PharmD recommendation (dated 4/14/25) requested the following: "This resident is currently on the anti-psychotic quetiapine 100 mg [every] 6 hours [as needed] with the diagnosis: agitation/hallucinations. Start 3/26/26. Number of times used: 2. *Please add verbiage (times) 14 days for [as needed] anti-psychotic orders* Please evaluate current diagnosis, behavior and	F 605	provider for further recommendations. 3. To ensure deficient practice will not recur, all licensed nurses including nursing leadership will be reeducated by 7/4/25 using Psychotropic Medications Policy. Facility will initiate new process of communicating pharmacy recommendations through Hospice Order/Communication Folder that will be utilized for communication of pharmacy recommendations. 4. To monitor performance and ensure on going compliance, DNS or designee will audit monthly pharmacy recommendations to ensuring Hospice psychotropic medications are communicated and address appropriately, monthly x3. The results of those audit findings will be brought to the QAPI Committee meeting by the DNS or designee for further recommendations. 5. Substantial compliance will be achieved by 7/4/25.		

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F 605	Continued From page 9 usage patterns and evaluate continues need. PRN [as needed] anti-psychotic orders cannot exceed 14 days and require direct prescriber evaluation of continuation." The PharmD noted went on to indicate choices to consider: 1. Discontinue [as needed quetiapine 2. New order for [as needed: _____](include duration (14 days) and rationale) 3. Adjust routine order to _____ A review of R43's electronic medical record (EMR) lacked documentation this recommendation had been reviewed by the prescribing physician. During interview on 5/21/25 at 10:33 a.m., nurse manager (RN)-A the facility does not do gradual dose reductions (GDRs) when a resident is receiving hospice services. Those are to be addressed by the hospice nurse / hospice provider. A review of R43's hospice folder, kept at the facility for communication purposes, lacked documentation the recommendation by the PharmD had been addressed. In a further telephone interview on 5/27/25 at 12:47 p.m., hospice registered nurse (Hospice) stated that hospice service had never received the PharmD communication for R43. Hospice stated had they received the recommendation, the prescribing hospice provider would have addressed this concern. In review of the facility's policy, entitled: Hospice - Provided Services - [Resident Services, [Long	F 605			

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F 605	Continued From page 10 Term Care], [Assisted Living], last revised 11/1/24 indicated the following under Procedure section: "5. The social worker or licensed nurse or [assisted living] Nurse/Manager will facilitate communication between resident and/or his/her family and hospice employees."	F 605			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609			7/4/25

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F 609	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents were reported timely to the State agency (SA) for 2 of 4 residents (R213 and R214) whose incidents were reviewed. Findings include: R213's admission Minimum Data Set (MDS) dated 4/24/25, identified R213 had moderate cognitive impairment and was dependent on staff for activities of daily living (ADLs). Diagnoses included depression, anxiety, radiation sickness, lung cancer, breast cancer, thyrotoxicosis (a condition where there is too much thyroid hormone in the body), muscle weakness, metabolic encephalopathy (a condition where a change in brain function, like confusion or decreased consciousness, is caused by an underlying metabolic or chemical imbalance in the body), diabetes and acute kidney failure. R213's care plan revised 5/4/25, indicated R213 had potential to develop pressure sores related to impaired mobility and incontinence with an intervention instructing staff to reposition R213 from side to side when in bed every two to three hours and as needed (PRN). the care plan also indicated R213 had an ADL self-care deficit related to weakness, recent bladder infection (UTI), recent cancer treatment and need for staff assistance with all ADLs. ALD interventions included bed-mobility assistance of two staff with positioning up in bed and turning from side to side, toileting assistance of one to two staff with sit-to-stand lift, large harness to use toilet, resident incontinent or urine and directed staff to			F 609	F609: Reporting Alleged Violations 1. Incidents for R213 were reported on 5/4/25 and R214 was reported on 5/1/25 to MDH. 2. All residents with Abuse and Neglect events have the potential to be affected by deficient practice. By 7/4/25, audit will be completed by administrator or designee to review facility incidents for timely reporting for the past 30 days. 3. To ensure deficient practice will not recur, facility will reeducate facility staff using Abuse and Neglect policy regarding identifying Abuse and Neglect and timely reporting will be completed by 7/4/25 or by next working shift. Facility staff will follow Abuse & Neglect policy and procedure for thorough investigation and reporting allegations of Abuse & Neglect to DOH. 4. To monitor performance and ensure on going compliance, Administrator or designee will audit all abuse and neglect events for complete investigations, documentation and timely reporting weekly x4 and monthly x2. The results of those audit findings will be brought to the QAPI Committee meeting by the DNS or designee for further recommendations. 5. Substantial compliance will be achieved by 7/4/25.		

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F 609	Continued From page 12 anticipate toileting needs/check/change/toilet R213 PRN. A Facility Reported Incident (FRI) was submitted to the SA on 5/4/25 at 12:12 p.m., (approximately 12 hours after facility staff discovered incident occurred) which identified R213 had been placed on a bedpan by nursing assistant (NA)-C at about 1:30 p.m. on 5/3/25. NA-C failed to return to R213 to check on status and did not report to NA-D that R213 was on the bedpan at change of shift. NA-D reported she asked R213 how she was doing, brought R213 food and fluids and repositioned in bed, however, NA-D failed to check/change R213 during her shift. At about 12:00 a.m. 5/4/25, registered nurse (RN)-C checked R213 for toileting needs, found R213 still had bedpan underneath her. R213 developed a deep tissue injury (a type of pressure injury where the underlying tissue is damaged, but the skin may appear intact. It's characterized by a localized discoloration, often purple or maroon, and may have a blood-filled blister. DTI can develop into a larger, open wound, but it's initially a localized injury.) due to the bedpan being placed for eleven and a half hours. When interviewed on 5/22/2025 at 2:10 p.m., NA-D stated she worked with R213 one other time two weeks prior, at that time R213 was fully responsive and communicated her needs. NA-D stated she had assumed R213 would utilize her call light and express her needs independently. NA-D had not been informed there were any changes in R213's status, R213 had not communicated any needs when NA-D was in the room nor did R213 inform staff she was on the bedpan.	F 609			

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F 609	Continued From page 13 When interviewed on 5/27/25 at 10:05 a.m., nurse manager (RN)-A stated she had been in the building morning of 5/4/25, had been informed by RN-C of the incident, went to R213 observed stage one pressure sore (the initial stage of skin breakdown caused by prolonged pressure on a specific area of the body) on R213's buttocks in the outline of the bedpan, expected the area would progress to a deep tissue injury. RN-A stated incidents of abuse, neglect and significant bodily harm were to be reported to the SA within 2 hours from when suspicion was formed, but the nurses did not have access to submit reports to the SA, this was completed by the administrator, director of nursing (DON) or social worker. R214 R214's discharge Minimum Data Set (MDS) dated 3/27/25, indicated R214 had intact cognition, and had diagnoses of hypertension (high blood pressure), atrial fibrillation (irregular heartbeat that originates in the heart's upper chambers), anemia (low red blood cells) and depression. A report was received by the SA, dated 5/1/25 at 12:59 p.m., which indicated R214 was seen in the clinic last week (4/22/25) for a visit after R214 was discharged from the transitional care unit (TCU) at facility. According to the report, R214 had been in and out of the facility twice prior to her being seen in clinic. R214 brought all her medications with her from home to her appointment and it was then discovered there were two bubble medication cards that had medications missing and a few remaining labeled with another resident's name. R214 reported to provider that she had been taking these medications at home. According to the report,			F 609			

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F 609	Continued From page 14 one of the medications was to lower blood pressure and R214 was recently in the hospital for low blood pressure. R214 also reported to provider a couple of falls between discharge from her last TCU stay and follow-up appointment in the clinic. According to the report, the incorrect medication R214 was taking could have contributed to R214 falling at home. According to the report, the reporter called the facility and reported this incident with RN-E. During interview on 5/20/25 at 12:13 p.m., RN-D stated R214 came to clinic for a follow up appointment and brought all her medications with her for the provider to review. Included were medications cards R214 received from the facility upon R214's discharge from the TCU. R214 stated she was taking all medications that she brought with her to the clinic. RN-D stated there were two medications (Lisinopril and Atorvastatin) prescribed to a person who was not R214, they kept and destroyed in the clinic. RN-D stated R214 reported couple incidents of being dizzy and falling at home since second discharge from the facility. RN-D stated R214 ingested approximately at least 11 doses of incorrect medications at home, resulting in low blood pressure that led to R214 falling four times in four days while at home, prompting and emergency department visit on 3/31/25. During interview on 5/27/25 at 11:14 a.m., RN-D stated she called the facility and spoke with RN-E and informed them of the medication error. During interview on 5/27/25 at 11:42 a.m., RN-E stated R214's clinic called and informed her that R214 had brought medications into her clinic appointment that were not prescribed to R214.			F 609			

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F 609	Continued From page 15 RN-E stated medications were prescribed for another resident residing at the facility. RN-E stated she believed medications were sent with R214 during discharge on 3/27/25. RN-E stated she notified nurse manager immediately. During interview on 5/27/25 at 4:32 p.m., RN-A stated incident was not reported to the SA and should have been reported to the SA immediately after being made aware of incident. RN-A stated, "it was an error on our part." During interview on 5/27/25 at 5:03 p.m., administrator stated reports to SA can be completed by herself, the director of nursing and the nurse managers. The nurses and nursing assistants could call in the report, but expectation was to call administrator or DON who would file the report online. Administrator was informed about the incident with R213 at 9:26 a.m. on 5/4/25, completed the report at 12:12 p.m. after she had spoke with the nurse consultant who stated the incident was harm and reportable to the SA. Administrator stated the time frame for reporting was two hours for bodily harm and 24 hours for everything else. Administrator stated incident with R214 should have been reported as soon as the facility was made aware of the incident. The facility Abuse and Neglect policy, dated 4/7/25, indicated if an employee receives an allegation of abuse, neglect, exploitation or misappropriation of resident/client property or witnesses suspected abuse, neglect or misappropriation of resident/client property, the employee will take measures to protect the resident/client, provided the safety of the employee is not jeopardized. The employee will	F 609			

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F 609	Continued From page 16 then report the allegation to a supervisor. The program coordinator, charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required and complete an initial investigation. If this is an injury of unknown origin, he or she also will attempt to determine the cause of the injury. The coordinator or charge nurse also will ensure that any potential for further abuse is eliminated by taking one of the following actions: a. If this is an allegation of employee to resident/client abuse, the employee will be removed from providing direct care to all residents/clients. Additionally, the employee will be placed on suspension pending the results of the internal investigation. Another employee will be assigned to complete the care of the resident/client. Contact the Human Resources Advisor for the location to assist with corrective action. b. If it is an allegation of resident/client to resident/client abuse, the residents/clients will be separated immediately, and both ensured a safe environment. Determine if a room change needs to be made. c. If family or other visitors are suspected of alleged abuse, they may not be allowed to visit the resident/client, or in any other way have access to the location, pending the results of the investigation. A designated individual will enter the event into the SAFE Event Reporting Portal per the Event Reporting Resident, Visitor, Employee policy. Notification procedures:			F 609			

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F 609	Continued From page 17 a) Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency. If applicable, Adult Protective Services will be notified where state law provides for jurisdiction in long-term care centers. - If there is an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident/client property, and/or there is serious bodily injury, then it will be reported immediately, but not later than two hours after the allegation is made. - If there is an allegation that does not involve abuse and there is no serious bodily injury, then it will be reported not later than 24 hours after the allegation is made. b) After the initial documentation of the event, if there is a need for additional documentation, this will be completed within the SAFE Event Reporting Portal per the Event Reporting Resident, Visitor, Employee policy. c) The investigation team (social worker, administrator and director of nursing services) will review all events no later than the next working day following the event. d) Ensure that someone is assigned to complete the investigation and that the care plan has been updated with any new interventions put into place. The investigation team will determine whether further investigation is needed. The social worker or the designated person will notify the designated agency(ies) in the state as soon as possible after reviewing the event; if designated agency(ies) have not been notified, the social worker or the designated person also will complete and submit any reports required by the designated agencies.	F 609			

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F 610 F 610 SS=D	Continued From page 18 Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to thoroughly investigate and protect residents from an allegation of neglect for 1 of 4 residents (R214) whose incidents were reviewed. Findings include: R214's discharge Minimum Data Set (MDS) dated 3/27/25, indicated R214 had intact cognition, and had diagnoses of hypertension (high blood pressure), atrial fibrillation (irregular heartbeat that originates in the heart's upper chambers), anemia (low red blood cells) and depression. A report was received by the SA, dated 5/1/25 at	F 610 F 610			7/4/25

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F 610	Continued From page 19 12:59 p.m., which indicated R214 was seen in the clinic last week (4/22/25) for a visit after R214 was discharged from the transitional care unit (TCU) at facility. According to the report, R214 had been in and out of the facility twice prior to her being seen in clinic. R214 brought all her medications with her from home to her appointment and it was then discovered there were two bubble medication cards that had medications missing and a few remaining labeled with another resident's name R214 reported receiving the bubble medication cards when she discharged from the TCU. R214 reported to provider she had been taking these medications at home. According to the report, one of the medications was to lower blood pressure, R214 was recently in the hospital for low blood pressure. R214 also reported to provider a couple of falls between discharge from her last TCU stay and follow-up appointment in the clinic. According to the report, one of the incorrect medication R214 was taking could have contributed to R214 falling at home. The facility was called and reported this incident with RN-E. During review on 5/27/25, 214's electronic health record (EHR) lacked documentation of investigation of medication error that was reported to the facility by an external party. During interview on 5/27/25 at 11:14 a.m., RN-D stated she called the facility and spoke with RN-E and informed them of the medication error. During interview on 5/27/25 at 11:42 a.m., RN-E stated R214's clinic called and informed her R214 had brought medications into her clinic appointment that were not prescribed to R214. RN-E stated medications were prescribed for	F 610	using Abuse and Neglect policy regarding identifying Abuse and Neglect for timely reporting and thorough investigation will be completed by 7/4/25 or prior to next working shift. Facility staff will follow Abuse & Neglect policy and procedure for thorough investigation and reporting allegations of Abuse & Neglect to DOH. 4. To monitor performance and ensure on going compliance, Administrator or designee will audit all abuse and neglect events for complete investigations, documentation and timely reporting weekly x4 and monthly x2. The results of those audit findings will be brought to the QAPI Committee meeting by the DNS or designee for further recommendations. 5. Substantial compliance will be achieved by 7/4/25.		

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F 610	Continued From page 20 another resident residing at the facility. RN-E believed the medications were sent with R214 during discharge on 3/27/25. RN-E notified the nurse manager immediately. During interview on 5/27/25 at 4:32 p.m., RN-A stated incident should have been reported to the SA and investigation should have been started immediately after being made aware of incident. RN-A stated, "it was an error on our part." During interview on 5/27/25 at 5:03 p.m., administrator stated report can be completed by herself, the director of nursing and the nurse managers. Administrator stated she would want staff to let the DON know so she could file the report and start an investigation. The facility Abuse and Neglect policy, dated 4/7/25, indicated if an employee receives an allegation of abuse, neglect, exploitation or misappropriation of resident/client property or witnesses suspected abuse, neglect or misappropriation of resident/client property, the employee will take measures to protect the resident/client, provided the safety of the employee is not jeopardized. The employee will then report the allegation to a supervisor. The program coordinator, charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required and complete an initial investigation. If this is an injury of unknown origin, he or she also will attempt to determine the cause of the injury. The coordinator or charge nurse also will ensure that any potential for further abuse is eliminated by taking one of the following actions:	F 610			

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F 610	Continued From page 21 a. If this is an allegation of employee to resident/client abuse, the employee will be removed from providing direct care to all residents/clients. Additionally, the employee will be placed on suspension pending the results of the internal investigation. Another employee will be assigned to complete the care of the resident/client. Contact the Human Resources Advisor for the location to assist with corrective action. b. If it is an allegation of resident/client to resident/client abuse, the residents/clients will be separated immediately, and both ensured a safe environment. Determine if a room change needs to be made. c. If family or other visitors are suspected of alleged abuse, they may not be allowed to visit the resident/client, or in any other way have access to the location, pending the results of the investigation. A designated individual will enter the event into the SAFE Event Reporting Portal per the Event Reporting Resident, Visitor, Employee policy. Notification procedures: a) Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency. If applicable, Adult Protective Services will be notified where state law provides for jurisdiction in long-term care centers. b) After the initial documentation of the event, if there is a need for additional documentation, this will be completed within the SAFE Event Reporting Portal per the Event Reporting Resident, Visitor, Employee policy. c) The investigation team (social worker,			F 610			

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F 610	Continued From page 22 administrator and director of nursing services) will review all events no later than the next working day following the event. d) Ensure that someone is assigned to complete the investigation and that the care plan has been updated with any new interventions put into place. The investigation team will determine whether further investigation is needed. The social worker or the designated person will notify the designated agency(ies) in the state as soon as possible after reviewing the event; if designated agency(ies) have not been notified, the social worker or the designated person also will complete and submit any reports required by the designated agencies.	F 610			
F 628 SS=G	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals;	F 628			7/4/25

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F 628	Continued From page 23 (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to	F 628			

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F 628	Continued From page 24 allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the	F 628			

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F 628	Continued From page 25 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding	F 628			

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F 628	Continued From page 26 bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and policy review, the facility failed to ensure that medications were accurately identified and dispensed upon discharge, resulting in one resident (R214) being sent home with another	F 628			
			F628 Discharge Process 1. Unable to correct for R214 due to discharged from facility. 2. All residents who discharge have the potential to be affected.		

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F 628	Continued From page 27 resident's (R221) medications. This failure led to R214 ingesting medications not prescribed to her. This resulted in actual harm when R214 required emergency medical intervention and hospitalization due to hypotension (low blood pressure). Findings include: R214's discharge Minimum Data Set (MDS) dated 3/27/25, indicated R214 had intact cognition, and had diagnoses of hypertension (high blood pressure), atrial fibrillation (irregular heartbeat that originates in the heart's upper chambers), anemia (low red blood cells) and depression. R214 was admitted to the transitional care unit (TCU) for rehab, on 3/14/25, following hospitalization with a primary diagnosis of hypertension with shortness of breath. R214's Discharge or Therapeutic Leave Medication List assessment dated 3/27/25, lacked a verified of medication reconciliation. Assessment identified the form of education that was provided to resident at time of discharge was paper handouts with no verbal education indicated. Hospital records dated 3/31/25, confirmed R214 had fallen four times in the last four days with one fall causing acute facial trauma which required sutures. Records also indicated R214 was experiencing orthostatic hypotension (drop in blood pressure with change in position) that was likely contributing to her falls. R214 was readmitted to the facility's TCU for	F 628	3. To ensure deficient practice will not recur, facility will reeducate all Licensed nursing staff regarding discharge process including medication review, education and verification of correct medications dispensed by 7/4/25 or prior to next working shift. Facility will initiate Nursing Discharge Checklist to facilitate a thorough and accurate discharge for residents. Discharge Medication List (UDA) User Defined Assessment will be utilized for medication review and education upon discharge. New process will be educated and initiated by 7/4/25. 4. To monitor performance and ensure on going compliance, DNS or designee will audit Nursing Discharge Checklist and resident medical record for thorough and complete discharge procedure weekly x4, monthly x2. The results of those audit findings will be brought to the QAPI Committee meeting by the DNS or designee for further recommendations. 5. Substantial compliance will be achieved by 7/4/25.		

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F 628	Continued From page 28 rehab, on 4/4/25, following hospitalization from 3/31/25 to 4/4/25 with a primary diagnosis of orthostatic hypotension. R214's Discharge Summary, dated 4/15/25, lacked verification of medication reconciliation and listing of current medications. Clinic visit note, dated 4/22/25, indicated "orthostatic hypotension, [R214's] blood pressure readings have remained soft, with a recent measurement of 102/76. It was discovered that she was mistakenly given another patient's medication upon TCU discharge [3/27/25], including lisinopril 20 mg, which is a blood pressure-lowering agent. This error may have contributed to her second hospitalization [3/31/25-4/4/25] (med pack of lisinopril she was taking was dated late February) and may have contributed to her falls. She has been advised to discontinue the use of lisinopril immediately. A follow-up with Good Samaritan will be conducted to address this medication error. Blood work will be ordered today to monitor her kidney function and potassium levels." R221's electronic medication record (EMR) indicated R221 prescribed Lisinopril was "not available" from 3/29/25 to 4/2/25. During interview on 5/20/25 at 12:13 p.m., registered nurse (RN)-D from R214's primary care provider's office stated R214 came to clinic for a follow up appointment and brought all her medications with her for the provider to review. R214 stated she was taking all medications that she brought with her. RN-D stated there were two medications (Lisinopril and Atorvastatin) with R221's name on them. These medications were	F 628			

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F 628	Continued From page 29 kept and destroyed in the clinic. RN-D stated R214 reported a couple incidents of being dizzy and falling at home since second discharge from the facility. RN-D stated R214 ingested approximately 11 doses of incorrect medications at home, resulting in low blood pressure that led to R214 falling four times in four days while at home, prompting an emergency department visit on 3/31/25 and hospitalization. During interview on 5/27/25 at 11:26 a.m., FM-B stated medications which did not belong to R214 were sent with her after being discharged on 3/27/25 with one medication that lowered blood pressure. FM-B stated R214 thought the other resident's name on the label of medications was the name of the ordering provider and did not think anything of it and assumed she was supposed to take the medications as they were sent home with her. FM-B stated R214 had intact cognition with no memory concerns. FM-B confirmed R214 had taken the incorrect medication that was sent home by facility after the first discharge and also after the second discharge. During interview on 5/27/25 at 11:37 a.m., RN-A stated the nurse manager (NM) obtained orders from the provider for discharge. NM then put together information in a discharge folder with information regarding other services to be provided in the home if applicable. RN-A stated the discharging nurse would notify the resident of any upcoming appointments which was also included in their discharge folder. Any medications in the facility, belonging to the resident, were sent with the resident and a fax was sent to the resident's preferred pharmacy with a seven-day order for all medications. RN-A			F 628			

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F 628	Continued From page 30 stated the list of medications was placed in discharge folder. During interview on 5/27/25 at 11:42 a.m., RN-E stated R214's clinic called and informed her R214 had brought medications into her clinic appointment that were not prescribed to R214. RN-E stated medications were prescribed for R221. RN-E believed the medications were sent with R214 during discharge on 3/27/25. RN-E notified the nurse manager immediately. RN-E stated when a resident discharged from the facility, she followed the facility's discharge checklists and sent all ordered medications with the resident. Attempts to contact R214 were unsuccessful. During interview on 5/27/25 at 3:46 p.m., RN-A stated she would expect the discharging nurse to go through each and every medication and ensure each medication was prescribed for the correct patient and was the correct medication and reviewed with the resident at time of discharge. RN-A stated the discharge medication list was placed in the discharge folder with the current medications and the last time medications was taken. During interview on 5/27/25 at 5:59 p.m., medical director (MD) stated she was not made aware of this situation. MD stated she would expect that each medication is reviewed with the current medication orders and also reviewed with the resident at the time of discharge and the medication list should be printed for the resident. MD stated medications are sent home with the resident at the time of discharge.	F 628			

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F 628	Continued From page 31 The facility Discharge and Transfer policy, dated 3/28/25, indicated the charge nurse or designated individual will: a. Complete a progress note - discharge b. Obtain an order from the physician for discharge to home with medications. c. Complete the Discharge or Therapeutic Leave Medication List UDA. d. Complete Miscellaneous Information section of the Admission Record. e. Complete and review any relevant portions of the PN - Teaching - Resident/Family. f. Complete the Discharge Summary.	F 628			
F 641 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. §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	F 641			7/4/25

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F 641	Continued From page 32 (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 interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with the potential for inaccurate federal reimbursement and resident care planning for 2 of 2 residents (R49 and R59) reviewed for MDS accuracy. Findings include: R49's quarterly MDS dated 4/10/25, indicated under "Section J" (J1700-B) Falls documented R49 did not have any falls since the last MDS Assessment (Admission MDS, submitted 1/14/25). In review of R49's electronic medical record (EMR), it was noted R49 had two falls since admission: 2/2/25 - R49 rolled out of bed and onto the floor 2/4/25 - R49 self transferred from wheel chair and fell to the floor During an interview on 5/21/25 at 10:33 a.m., nurse manager (RN)-A and interim director of nursing (DON)-A stated R49's two falls should have been documented on the 4/10/25 quarterly MDS. R59's Discharge Return Not Anticipated MDS submission dated 3/6/25, indicated under	F 641	F641 Accuracy of Assessments 1. MDSs for R49 and R59 will be amended by 7/4/25. 2. All residents have the potential to be affected by inaccurately MDS coding related to "Section J" (J1700-B) and "Section A" (A2105) Discharge Status. Facility will audit all resident's MDS "Section J" (J1700-B) and "Section A" (A2105) Discharge Status for the last quarter of this year, adjustments will be made as needed by 7/4/25. 3. To ensure deficient practice will not recur, facility will be reeducate by Clinical Reimbursement Consultant by 7/4/25 regarding accurate MDS coding for Section J and accurate Discharge coding. MDS nurse will follow policy and procedure regarding accuracy of coding. 4. To monitor performance and ensure on going compliance, DNS or designee will audit 20% of MDSs submitted and 20% of Discharges for accuracy of coding related to "Section J" (J1700-B) and "Section A" (A2105) Discharge Status coding weekly x4, monthly x2. The results of those audit findings will be brought to the QAPI Committee meeting by the DNS or designee for further recommendations. 5. Substantial compliance will be achieved by 7/4/25.		

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F 641	Continued From page 33 "Section A" (A2105) Discharge Status documented R59 was discharge to :Short-Term General Hospital." In review of R59's electronic medical record (EMR), documented the following in R59's progress notes: "3/6/2025 [1:33 p.m.] Discharge -Home, Assisted Living, Other Facility, Involuntary Destination: Home Method of transportation and who accompanied resident, included their relationship to resident: daughter and son in law transported resident home via own vehicle at [12:30 p.m.]. Medications reviewed. Notes: 1 card of 28 tramadol [tablets] and own bottle of tramadol 7 [tablets] sent home with resident." During an interview on 5/21/25 at 10:33 a.m., nurse manager (RN)-A and interim director of nursing (DON)-A, RN-A stated the discharge MDS submission was coded incorrectly. and verified R59 had discharged to home. A facility' policy on MDS completion was requested, however, none was received.	F 641			
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F 644			7/4/25

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F 644	Continued From page 34 §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the county (designated state mental health authority) when 1 of 3 residents (R2) had a new on-set of mental illness. Findings include: R2's annual Minimum Data Set (MDS) dated 4/10/25, indicated R2 had moderate cognitive impairment and was dependent on staff for activities of daily living (ADLs). R2's admission record printed 5/18/25, indicated R2 had diagnoses of unspecified dementia with effective date of 10/1/22, psychotic disorder with delusions effective date 2/10/22, adjustment disorder with mixed anxiety and depressed mood effective date 3/10/22. R2's current, undated medication administration record (MAR) identified R2 had an antipsychotic medication, Haloperidol 0.5 milligrams (mg) every two hours as needed for agitation, delusions, or psychosis. R2's care plan revised 11/27/23, identified R2	F 644	F644 Coordination of PASARR and Assessments 1. Facility will update R2's PASARR by 7/4/25. 2. All residents with new mental illness diagnoses have the potential to be affected by deficient practice. Social Service or designee will audit all residents with new mental illness diagnoses and compare to current PASARR to ensure PASARR is updated. Audit will be completed by 7/4/25. 3. To ensure that deficient practices do not recur, the facility has reviewed its Pre-Admission Screening and Resident Review (PASARR) – Rehab Policy and Procedure. As part of this effort, a new internal process was developed to align with the updated policy. The facility will implement a revised protocol: new mental illness diagnoses will be discussed during the morning Clinical Meeting by the Interdisciplinary Team. This process promotes effective communication, accurate identification, and timely updates to PASARR documentation.		

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F 644	Continued From page 35 had mood and behavior problems related to major depression, psychosis, recent history of hallucinations and delusion, verbally rude, angry outbursts, and spitting. R2's 4/14/16, Pre-Admission Screening (PAS)-level I, did not identify dementia, psychotic disorder with delusions or adjustment disorder with mixed anxiety and depressed mood. and did not indicate a need for a Pre-admission Screening and resident review (PASARR)-level II to be completed. When interviewed on 5/27/25 at 3:06 p.m., social worker (SW)-A stated had not done a PASRR in a long time, could not think of a situation when a PASRR would have to be completed after the resident admitted. Facility PASARR policy dated 12/30/24, indicated If a resident was diagnosed with a mental disorder during their stay the facility would contact the designated state agency for a level II screening to be completed.	F 644	Interdisciplinary team will be educated on new process with implementation by 7/4/25 or prior to next shift. 4. To monitor performance and ensure on going compliance, Social Services or designee will audit 20 % of resident population for accurate and updated PASARR related to new mental illness diagnoses. The results of those audit findings will be brought to the QAPI Committee meeting by the DNS or designee for further recommendations. 5. Substantial compliance will be achieved by 7/4/25.		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission.	F 655		7/4/25	

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F 655	Continued From page 36 (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete and implement a baseline care plan within 48 hours of admission for 3 of 5 residents (R35. R41 and R215) reviewed for care plans.			F 655	F655 Baseline Care Plan 1. Facility reviewed, completed and implemented Baseline Care Plan for R35 by 7/4/25. R41 discharged 5/19/25, unable to provide correction to medical record. R215 discharge 5/24/25, unable to		

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F 655	Continued From page 37 Findings include: R35's admission Minimum Data Set (MDS) dated 4/21/25, identified R35 had intact cognition and required assistance with all activities of daily living (ADLs). R35's diagnoses included end stage renal disease, heart failure, hypertension, cirrhosis, diabetes mellitus, arthritis, depression, dependence on renal dialysis, and chronic pain. R35's electronic health record (EHR) indicated R35 was admitted to the facility on 4/15/25. EHR lacked evidence a baseline care plan had been initiated within 48 hours of admission. EHR indicated baseline care plan was developed on 4/18/25 and indicated R35 was dependent on staff for transfers, toileting and grooming/bathing. R41's admission MDS dated 5/1/25, identified R41 had moderate cognitive impairment and required assistance with ADL's. R41's diagnoses included acute on chronic systolic (congestive) heart failure, atrial fibrillation, coronary artery disease, heart failure, hypertension, renal failure, localized edema, presence of prosthetic heart valve, and presence of coronary angioplasty implant and graft. R41's EHR indicated R41 was admitted to the facility on 4/25/25. EHR lacked evidence a baseline care plan had been initiated within 48 hours of admission. EHR indicated baseline care plan was developed on 4/29/25 and indicated R41 and indicated R41 was dependent on staff for transfers, toileting and grooming/bathing. R215's admission MDS dated 5/14/25, identified R215 had intact cognition and required moderate assistant with ADL's. R215's diagnoses included	F 655	provide correction to medical record. 2. All new admissions admitted to the facility have the potential to be affected by deficient practice. Facility will review residents who have admitted to the facility within the last 2 weeks to ensure proper baseline care plans are in place. Audit will be completed by 7/4/25. 3. To ensure that deficient practices do not recur, the facility has reviewed its Care Plan- R/S, LTC, Therapy & Rehab Policy and Procedure. As part of this effort, a new internal process was developed to align with the policy. The facility will implement a new process of New Admission review during clinical morning meeting as an IDT team to review for complete Baseline Care Plans of newly admitted resident. Facility will educate clinical leadership team on new process by 7/4/25. All Licensed nurses will be educated on Baseline Care Plans by 7/4/25. 4. To monitor performance and ensure on going compliance, DNS or Designee will audit all new admissions for complete and implemented Baseline Careplans within 48 hours of admission weekly x4, monthly x2. The results of those audit findings will be brought to the QAPI Committee meeting by the DNS or designee for further recommendations. 5. Substantial compliance will be achieved by 7/4/25.		

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F 655	Continued From page 38 hypertension, renal failure, fracture, anxiety disorder and depression. MDS also indicated R215 was receiving dialysis services. R215's EHR indicated R215 was admitted to the facility on 5/8/25. EHR lacked evidence a baseline care plan had been initiated within 48 hours of admission. EHR indicated baseline care plan was developed on 5/13/25 and indicated R215 was dependent on staff for transfers, toileting and grooming/bathing. During interview on 5/27/25 at 3:49 p.m., registered nurse manager (RN)-A stated baseline care plans should be completed within 24 hours of admission to the facility. RN-A confirmed a baseline care plan had not been completed with 48 hours of admission for R35, R41 and R215. RN-A stated baseline care plans are important to complete for resident safety and so staff know how to care for the resident. The facility Care Plan facility, dated 12/2/24, indicated facility would develop a comprehensive care plan using an interdisciplinary team approach and to provide guidance to the interdisciplinary team in developing the initial care plan. Baseline care plan includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. A baseline care plan will be developed upon admission according to federal and state regulations. The location must provide the resident and resident representative with a written summary of the baseline care plan.	F 655			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656			7/4/25

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F 656	Continued From page 39 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656			

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F 656	Continued From page 40 requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed, accurate, and revised to assure assessed care needs were implemented for 1 of 2 residents (R35) reviewed for dialysis. Findings include: R35's admission Minimum Data Set (MDS) dated 4/21/25, identified R35 had intact cognition and required assistance with all activities of daily living (ADLs). R35's diagnoses included end stage renal disease, heart failure, hypertension, cirrhosis, diabetes mellitus, arthritis, depression, dependence on renal dialysis, and chronic pain. R35's physician orders, print date of 5/21/25, indicated an order for dialysis on Monday/Wednesday/Friday at Fresenius Waconia with a start date of 4/15/25. R35's care plan, print date of 5/21/25, failed to include dialysis including goals of treatment, and interventions allowing the nurse to assess the intervention's outcome and potentially revise care based on the resident's status. During interview on 5/27/25 at 3:49 p.m., registered nurse manager (RN) stated the nurse managers are responsible for updating the			F 656	F656 Develop/Implement Comprehensive Care Plan 1. Facility updated R35's care plan to include his Dialysis. 2. All residents who receive dialysis have the potential to be affected by deficient practice. Facility will review and update residents requiring dialysis for person-centered care plans as needed by 7/4/25. 3. To ensure deficient practice will not recur, facility will initiate a new process of New Admission review during clinical morning meeting as an IDT to ensure procedures such as Dialysis are included in resident Baseline/Comprehensive Care plans. Facility will educate clinical leadership team on new process by 7/4/25. All Licensed nurses will be educated on Baseline Care Plans by 7/4/25. 4. To monitor performance and ensure on going compliance, DNS or Designee will audit all Dialysis resident records for complete Comprehensive Care plans weekly x4, monthly x2. The results of those audit findings will be brought to the QAPI Committee meeting by the DNS or designee for further recommendations. 5. Substantial compliance will be achieved by 7/4/25.		

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F 656	Continued From page 41 resident's care plans. RN-A stated if a resident was receiving dialysis, it should be included in the care plan so staff are watching for signs and symptoms and could recognize problems earlier to treat sooner. RN-A stated it was important to include dialysis on the care plan to help with implementation of interventions or staff being aware so symptoms could be recognized and acted on. RN-A confirmed R35's care plan did not include that R35 was receiving dialysis services nor was there any dialysis goals/interventions related to care for dialysis patients. The facility Comprehensive Care Plan facility, dated 1/31/25, indicated facility would develop a person-centered care plan for each resident that includes measurable objectives and timetables to meet his or her physical, mental, spiritual and psychosocial well-being. The facility would provide an ongoing method of assessing, implementing, evaluating and updating the resident's care plan to help maintain the resident's highest practicable level of function, including culturally competent and trauma informed care.	F 656			
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657			7/4/25

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F 657	Continued From page 42 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan to include current behaviors for 1 of 1 residents (R51), toileting needs for 1 of 1 residents (R20), discontinued medications for 1 of 1 residents (R24), resident receiving tube feedings for 1 of 1 residents (R7), and falls for 1 of 1 residents (R55) in the sample whose care plans were reviewed. Findings include: R51's Face Sheet printed 5/27/25, indicated the diagnoses of Alzheimer's disease, dementia with behavioral disturbances, anxiety disorder, restlessness and agitation. R51's admission minimum data set (MDS) dated 2/27/25, identified R50 was cognitively impaired and required extensive assistance with activities of daily living.	F 657	F657 Care Plan Timing and Revision 1. Resident care plans were reviewed and revised as needed related to the following care areas per resident: Behavior needs for R51, toileting needs for R20, discharged medications for R24, Tube Feeding orders for R7, and falls for R55. 2. All residents have the potential to be affected by deficient practice. Facility will begin care plan reviews and updates as needed, beginning 6/27/25 to review for current Behaviors, toileting needs, discontinued medications, tube feeding and falls to ensure care plans are accurately revised. 3. To ensure deficient practice will not recur, facility will initiate clinical morning meeting utilizing PCC dashboard alerts and order listing reports review that will		

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F 657	Continued From page 43 During observation and interview on 5/18/25 at 4:24 p.m., it was observed that R51 had long finger nails on all fingers and thumbs. Some of which were 1/4 inched in length. R51 was also noted to have been unshaven, noting a rechargeable razor on resident's bed. R51 stated, "I was meaning to cut them (finger nails)." R51 stated he had just completed his shaving. General observations throughout each day (5/19/25 and 5/20/25), noted no change in R51's nail length nor shaving. An interview on 5/20/25 at 11:57 a.m., nursing asistant (NA)-A stated R51 was independent with his cares, with reminders for clean clothes and showering in his room. NA-A stated R51 refused to have staff assist with his care. NA-A stated staff have tried to shave and trim R51's nails, but he would not allow. NA-A stated reisdnet nails are usually trimmed on bath days. During an interview on 5/20/25 at 1:01 p.m., the bath aid - trained mdication assistant (TMA)-A stated R51's bath day (shower) is scheduled for Thursdays. TMA-A stated R51 will not allow staff to assist with his shower, however, she frequently checked on this due to his confusion, becomes easily distracted 1/2 way through and does not complete the task. She has not been able to trim his nails or shave him, as he stated he is able to. In review of the R51's assessment, Functional Abilities and Goals - Admission/Start of Skilled Care Complete Admission, dated 2/22/2025, the following was documented: - Self Care - Needed Some Help - Resident needed partial assistance from another person to	F 657	include resident change in condition including behaviors and change toileting needs, falls, and order change review. Facility will educate clinical leadership team and implement new clinical meeting template process by 7/4/25. 4. To monitor performance and ensure on going compliance, DNS or Designee will audit random 20% of resident population for accuracy of care plans including timely revisions weekly x4, monthly x2. The results of those audit findings will be brought to the QAPI Committee meeting by the DNS or designee for further recommendations. 5. Substantial compliance will be achieved by 7/4/25.		

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F 657	Continued From page 44 complete activities. - Functional Cognition - Needed Some Help - Resident needed partial assistance from another person to complete activities - Personal Hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). - Admission Performance - Substantial/maximal assistance In review of R51's care plan, the document lacked both resident's needs in care provision, as well as resident's behavior of care assistance refusal. In an interview on 5/21/25 at 11:03 a.m., nurse manager (RN)-A stated R51 is not independent with his cares and needs set up, cues and reminders. RN-A stated 51's care plan is lacking residents behavior to complete and/or allow staff to assist with his care. RN-A stated this will need further assessment and input from resident family and facility staff. R20's Clinical Physicians Orders, printed 5/27/25, indicated R20's main diagnosis was "other mechanical complication of implanted electronic neurostimulator of spinal cord electrode (lead)." R20's admission MDS dated 4/27/25, identified R20 was cognitively intact and required extensive assistance with activities of daily living, including toileting During an interview on 05/19/25 at 9:16 a.m., R20 stated since her back surgery, she has needed a lot of help with her toileting, and was especially concerned about her bowels not being regulated			F 657			

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F 657	Continued From page 45 appropriately. In review of R20's Functional Abilities - Current Performance assessment dated 5/13/25, indicated R20 required "supervision or touching assistance" with toileting. In an interview on 5/21/25 at 9:11 a.m., registered nurse (RN)-B stated R20 has had ongoing issues with bowel movements, more so, not wanting to be toileted. RN-B stated R20 had been refusing to be toileted and or have her incontinence brief changed, regardless if she was incontinent of urine or stool. RN-B stated she made an agreement with R20 that staff would be allowed to check and change R20, and provide peri-care at that time, shiftly. Review of R20's Care Plan last revised 5/2/25, lacked information on R20's toileting needs and the assistance needed to be provided. During interview on 5/21/25 at 11:09 a.m., RN-A stated R20 should have had toileting needs and interventions added to her care plan. R24's Order Recap Report, printed 5/20/25, indicated the diagnoses of malignant neoplasm of breast, with lumps / masses of head and neck, anxiety disorder and changes in cognitive function. R24 was receiving hospice services. R24's significant change minimum data set (MDS) dated 3/6/25, identified R50 was severely cognitively impaired and required extensive assistance with activities of daily living. R24's anastrozole was discontinued on 2/24/25. R24 was admitted to Ridgeview Hospice for comfort cares			F 657			

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F 657	Continued From page 46 on 2/26/25. In review of R24's Care Plan last revised 4/14/25, the following care plan concern was documented: - "The resident has an alteration in hematological (related to the study of blood and blood-forming tissues, including the bone marrow, spleen, and lymph nodes) status [related to] [history of] breast cancer {and the] use of anastrozole (is a nonsteroidal aromatase inhibitor used in the treatment of breast cancer)." During interview on 5/21/25 at 11:00 a.m., RN-A stated R24's anastrozole was discontinued, after having a discussion with residents family, when R20 enrolled into hospice services. The anastrozole was not a covered medication while on hospice. RN-A stated R24's care plan should have been updated. R7 R7's quarterly MDS dated 3/6/25, indicated R7 was cognitively intact, was independent with activities of daily living (ADLs) and had a feeding tube. R7's face sheet printed 5/18/25, indicated R7 had diagnoses of dysphagia (difficulty swallowing), gastrostomy status (opening into the stomach from the abdominal wall, made surgically for the introduction of food.) gastro-esophageal reflux disease (GERD), and hypertension. R7's care plan last revised 11/17/24, indicated R7 had a self-care deficit related to tube feeding with an intervention of nothing by mouth (NPO) - tube feeding. Care plan also indicated R7 required tube feeding related to dysphagia with and intervention of no water pitcher at bedside due to	F 657			

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F 657	Continued From page 47 NPO status. On 1/10/25, R7 received a new order for regular diet, regular texture, with thin liquids. Resident desired regular diet for quality of life. Okay to provide any food items per resident request. However, R7's care plan was not updated regarding change in NPO status. When interviewed on 5/18/25 at 5:11p.m., R7 stated he ate food for pleasure, tended to request easy to swallow foods like scrambled eggs and mashed potatoes. R7 hoped to increase his oral intake and eventually have the tube feeding removed. When interviewed on 5/21/25 at 11:15 a.m., nurse manager (RN)-A stated care plans were to be updated by the nurse manager as soon as they were notified of a change or during the next assessment period. RN-A stated R7's care plan should have been updated when diet order was changed in January 2025, diet change on care plan was also not completed during assessment period for quarterly MDS in March 2025. R55 R55's admission MDS dated 4/10/25, indicated R55 had moderate cognitive impairment and required extensive assistance with ADL's. R55's face sheet printed 5/18/25, indicated R55 had diagnoses of dementia, neurocognitive disorder with Lewy bodies (a progressive brain disorder characterized by cognitive decline, fluctuating alertness, visual hallucinations, and Parkinsonism symptoms), age-related macular degeneration, difficulty walking and repeated falls.	F 657			

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F 657	Continued From page 48 R55's fall care area assessment (CAA) dated 4/13/25, identified R55 had no recent falls, was at risk for falls related to wandering behavior, impaired cognition, and new admission. R55's care plan last revised 5/2/25, indicated R55 had an actual fall related to forgetfulness and not wearing proper footwear. With interventions which required staff to ensure R55 wore gripper socks if shoes not worn dated 4/17/25; sign connected to walker with reminder to bring walker with dated 4/24/25; and staff to complete frequent checks on resident throughout the day dated 5/2/25. However, there was no indication the fall care plan or interventions were updated regarding R55's frequent falls. R55 admitted to the facility on 4/4/25. Review of progress notes and incident indicated R55 had 18 or more falls since he was admitted to the facility. R55 was sent to the emergency room on 5/11/25 due to repeated falls, hospital discharge summary dated 5/14/25 indicated R55 had fallen at least 12 times in the past three days without injury. When interviewed on 5/27/25, at 4:06 p.m. RN-A stated she had reviewed R55's care plan but was unable to speak to why the care plan had not been updated regarding frequent falls or any interventions that may have been changed due to the other nurse manager that was responsible for the unit R55 resided on was no longer employed at the facility. The expectation was the care plan should have been updated when falls were reviewed, and new interventions were put into place. A facility Comprehensive Care Plan and Care	F 657			

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F 657	Continued From page 49 Conferences- Rehab/Skilled, Therapy and Rehab policy dated 1/31/25, indicated the purpose to provide an ongoing method of assessing, implementing, evaluating and updating the residents care plan to help maintain the residents highest practicable level of function. The policy directs care plans to be reviewed and revised with each MDS completed, in addition care plans must be revised as the residents needs or status changed.			F 657			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure as needed (PRN) medications were administered per physician's order for 1 of 1 resident (R20) reviewed for edema. Findings include: R41's admission Minimum Data Set (MDS) dated 5/1/25, identified R41 had moderate cognitive impairment and required assistance with activities of daily living (ADL)'s. R41's diagnoses included acute on chronic systolic (Congestive) heart failure, atrial fibrillation, coronary artery disease,			F 684	F684 Quality of Care 1. Resident 41 discharged from facility on 5/19/25, unable to make changes for resident. 2. Residents with PRN Diuretics with parameters have the potential to be affected by deficient practice. By 7/4/25, DNS or Designee will audit for other residents with PRN Diuretics. 3. To ensure deficient practice will not recur, facility has reviewed Point Click Care Orders Management Booklet which includes transcription of PRN orders including details content of orders and		7/4/25

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F 684	Continued From page 50 heart failure, hypertension, renal failure, localized edema, presence of prosthetic heart valve, and presence of coronary angioplasty implant and graft R41's physician orders with print date of 5/19/25, indicated R41 had an order for daily weights in the morning for heart failure with reduced ejection fraction (HFrEF) and to update physician assistant (PA) or medical doctor (MD) if increased of three pounds in a day or five pounds in a week. R41 also had an order for Torsemide 20 milligrams (mg) as needed (PRN) for HFrEF daily if weight exceeds 116.0 pounds with a start date of 5/13/25. During review of R41's electronic health record (EHR), noted EHR lacked documentation of administration of PRN medication on 5/13/25, 5/14/25, 5/15/25, 5/16/25, 5/17/25, 5/18/25 and 5/19/25 when it was noted R41's weight exceeded 116.0 pounds. R41's weight documentation, in EHR, indicated increased weight gain overnight on the following dates: -5/13/25 at 8:20 a.m., weight was documented as 116.6 lbs. (pounds) - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. -5/14/25 at 8:48 a.m., weight was documented as 116.2 lbs. - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. -5/15/25 at 9:06 a.m., weight was documented as 116.8 lbs. - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. -5/16/25 at 1:20 p.m., weight was documented as	F 684	accuracy of order entry. All licensed nurses will be educated by DNS or Designee by 7/7/25 or prior to next working shift, using Point Click Care Orders Management Booklet which includes transcription of PRN orders including details content of orders and accuracy of order entry. As part of this effort, a new internal process was developed to align with the Point Click Care Orders Management Booklet. Facility will initiate clinical morning meeting utilizing order listing reports reviewing new orders including PRN diuretics or other medications with parameters. During clinical morning meeting IDT team will review weights for residents with PRN diuretics. Facility will educate clinical leadership team and implement new clinical meeting template process by 7/4/25. 4. To monitor performance and ensure on going compliance, DNS or Designee will audit Order listing report that will include any PRN Diuretic orders for review including a weight review if parameters are indicated weekly x4, monthly x2. The results of those audit findings will be brought to the QAPI Committee meeting by the DNS or designee for further recommendations. 5. Substantial compliance will be achieved by 7/7/25.		

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F 684	Continued From page 51 117.8 lbs. - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. -5/17/25 at 12:21 p.m., weight was documented as 118.8 lbs. - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. -5/18/25 at 9:28 a.m., weight was documented as 116.8 lbs. - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. -5/19/25 at 10:33 a.m., weight was documented as 117.2 lbs. - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. R41's progress notes lacked documentation of increased weight and indicated: - 5/12/25 indicated R41 had an appointment at Minneapolis Heart and orders were changed for Torsemide as needed order to once daily as needed for weight excess of 116 pounds and an order for compression stockings to bilateral lower extremities daily for edema. - 5/19/25 at 11:19 p.m., indicated R41 was sent to the emergency department for low oxygen saturations of 84% and complaints of shortness of breath. - 5/20/25 indicated R41 was hospitalized with pneumonia and fluid overload. R41's electronic medical administration record (MAR) lacked documentation of administration of as needed Torsemide as ordered by cardiologist. During observation on 5/18/25 at 3:17 p.m., R41 had 2+ pitting edema noted in his bilateral lower extremities.	F 684			

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F 684	Continued From page 52 During observation and interview on 5/19/25 at 3:30 p.m., R41 was seated in a wheelchair in his room with oxygen on flowing at two liters per minute via nasal cannula, which he did not have on previously. R41 had edema noted in his bilateral lower extremities. R41 stated he had a dry cough and stuffy nose that started on 5/19/25 and it was harder for him to breath today. During interview on 5/20/25 at 8:10 a.m., registered nurse (RN)-E stated R41 was sent to the ER on 5/19/25 in the evening. RN-E stated R41 had low oxygen saturations all day on 5/19/25 with his breathing getting worse as the day went on. RN-E updated provider and obtained an order for a chest x-ray to be completed and an order for Mucinex. RN-E stated R41 had daily weights due to his diagnoses of congestive heart failure and there were no parameters of prn orders related to daily weights. RN-E stated R41 had edema and his scheduled torsemide order was increased approximately a week and a half ago. RN-E reviewed R41's orders and stated "oh, there is a prn order of torsemide." RN-E confirmed R41 should have received the prn dose of torsemide for the past seven days due to his weights being above 116.0. RN-E stated R41's increased shortness of breath could have been caused by not receiving the prn dose of torsemide as ordered. During interview on 5/20/25 at 11:02 a.m., R41's primary physician stated R41 had a history of congestive heart failure and was a very high-risk patient due his CHF. Physician stated the prn order of Torsemide was ordered by R41's cardiologist but he would expect the facility to administer medication as ordered. Physician stated he saw R41 the morning of 5/19/25 with	F 684			

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F 684	Continued From page 53 R41 having crackles in lower lobes and localized edema in bilateral lower extremities. Physician stated he ordered a chest x-ray to be obtained as R41 can go into an acute exacerbation very quickly and can decompensate at any time. During interview on 5/21/25 at 8:41 a.m., health unit coordinator (HUC) stated she was responsible for processing and entering new orders and once entered it would be checked by a nurse. HUC stated PRN orders are added to the existing scheduled orders and should pop up for nursing on the MAR. During interview on 5/21/25 at 8:25 a.m., licensed practical nurse (LPN)- B stated R41 had orders for daily weights to be completed and there were no parameters of prn orders related to daily weights. During interview on 5/21/25 11:29 a.m., registered nurse manager (RN)-A stated orders are processed by the HUC and a nurse would double check the order. RN-A stated if resident had a scheduled dose of ordered medication, the prn order would be added to the scheduled dose. RN-A stated the parameters for the prn dose would be displayed on the bottom on the EMAR (electronic medication administration record). RN-A reviewed R41's EMAR and stated nursing would not have seen the prn order with the way it was entered. Nursing would have to go into the PRN tab to see if R41 had a PRN dosage. The prn order should have been entered as a separate order or with the daily weights, so staff were aware of available medication. RN-A reviewed R41's weights and stated R41 should have received seven doses of prn torsemide in the past seven days as weight was over 116.0.	F 684			

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F 684	Continued From page 54 RN-A stated R41 was hospitalized for shortness of breath and fluid on his lungs and the prn dose could have made a difference with managing his symptoms. Attempted to contact R41's prescribing cardiologist on 5/20/25 at 12:27 p.m., 5/21/25 at 9:59 a.m., and again on 5/21/25 at 2:08 p.m. with no success. The facility Medication Administration policy, dated 4/8/25, indicated the facility would promote resident/family understanding of medication therapy, would administer medications correctly and in a timely manner and would schedule medications effectively. When PRN medications are given, facility would evaluate and document the efficacy of the medication. If using non-licensed personnel to dispense medications, the follow-up should be done by a licensed nurse.	F 684			
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686			

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F 686	Continued From page 55 by: Based on interview and document review the facility failed to assure that 1 of 3 residents (R213) reviewed for pressure ulcers received care and services to prevent occurrence of newly developed pressure ulcer. This failure resulted in actual harm to R213 when the facility failed to follow R213's care plan resulting in the development of a deep tissue injury (a type of pressure injury where the underlying tissue is damaged, but the skin may appear intact. It's characterized by a localized discoloration, often purple or maroon, and may have a blood-filled blister. deep tissue injury can develop into a larger, open wound, but it's initially a localized injury). Although noncompliance was present at the time of the event, the facility implemented appropriate corrective action prior to the survey resulting in a finding of past-noncompliance for R213. Findings include: A Facility Reported Incident (FRI) was submitted to the State Agency (SA) on 5/4/25 at 12:12 p.m., (approximately 12 hours after facility staff discovered incident occurred) which identified R213 had been placed on a bedpan by nursing assistant (NA)-C at about 1:30 p.m. on 5/3/25. NA-C failed to return to R213 and did not report to NA-D that R213 was on the bedpan at change of shift. NA-D reported she had asked R213 how she was doing, brought R213 food and fluids and repositioned in bed, however, NA-D failed to check/change R213 during her shift. At about 12:00 a.m. on 5/4/25, registered nurse (RN)-C checked R213 for toileting needs, found R213 still had bedpan underneath her. R213 developed a deep tissue injury due to the bedpan being in	F 686	Past noncompliance: no plan of correction required.		

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F 686	Continued From page 56 place for eleven and a half hours. R213's admission Minimum Data Set (MDS) dated 4/24/25, identified R213 had moderate cognitive impairment and was dependent on staff for activities of daily living (ADL's). Diagnoses included depression, anxiety, radiation sickness, lung cancer, breast cancer, thyrotoxicosis (a condition where there is too much thyroid hormone in the body), muscle weakness, metabolic encephalopathy (a condition where a change in brain function, like confusion or decreased consciousness, is caused by an underlying metabolic or chemical imbalance in the body), diabetes and acute kidney failure. R213's care plan revised 5/4/25, indicated R213 had potential to develop pressure sores related to impaired mobility and incontinence with an intervention instructing staff to reposition R213 from side to side when in bed every two to three hours and as needed (PRN). The care plan also indicated R213 had an ADL self-care deficit related to weakness, recent bladder infection (UTI), recent cancer treatment and need for staff assistance with all ADL's. ALD interventions included bed-mobility assistance of two staff with positioning up in bed and turning from side to side, toileting assistance of one to two staff with sit to stand lift, large harness to use toilet, resident incontinent or urine and directed staff to anticipate toileting needs/check/change/toilet R213 PRN. Resident Kardex dated 5/6/25, indicated R213 required assistance of one to two staff to turn and repositioning side to side when in bed every two to three hours and PRN. R123 required assistance of one to two staff with standing lift,	F 686			

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F 686	Continued From page 57 used large harness when toileted. Resident was incontinent or urine, wore large briefs. Staff were directed to check/change/toilet R213 PRN. Staff were directed to anticipate toileting needs. A facility wound assessment dated 5/4/25 at 12:54 p.m., indicated R213 had a suspected deep tissue injury to buttock. Area described as red in color, warm to the touch, and was non-blanchable (discoloration or redness that does not fade or turn white when pressed). A facility wound data collection assessment dated 5/4/25 at 2:47 p.m., identified R213 had an area on left lower lateral (outer) buttock that measured 1.25 centimeters (cm) by 0.6 cm was red, warm and inflamed. On left upper lateral buttock there was an area measured as 0.8 cm by 0.4 cm was red and warm to touch. On left upper medial (closer to center) buttock deep tissue injury measured at 1.5 cm by 1 cm red and warm to the touch. On right buttock a vertical deep tissue injury measured 24 cm by 2 cm that was non-blanchable red and purple in color, warm to touch with induration (hardening or thickening of the skin). Left buttock had vertical deep tissue injury measured at 26 cm by 4 cm, area was non-blanchable red and purple in color, was warm to the touch, with induration of skin. Progress note dated 5/4/25 at 7:42 p.m., indicated R213 was sent to the hospital due to change in mental status, was not alert and was very lethargic (sluggish, lack energy, drowsy, and decreased mental status). Hospital note dated 5/5/25, wound assessment indicated R213 appeared to have been left on a bedpan or similar device. The deep tissue	F 686			

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F 686	Continued From page 58 pressure injury evolved into a stage two pressure injury (partial-thickness skin loss with the epidermis (top layer) and dermis (underneath layer) affected) in 3 areas. Deep tissue pressure injuries can continue to progress even when the pressure is relieved as the damage is already done. induration noted on both sides of injury. On 5/12/25, deep tissue injury was purple, top left area developed eschar (layer of dead tissue typically black in color.) When interviewed on 5/22/2025 at 2:10 p.m., NA-D stated had worked with R213 one other time two weeks prior, at that time R213 was fully responsive and communicated her needs. NA-D stated she had assumed R213 would utilize her call light and express her needs independently. NA-D stated they had not been informed there were any changes in R213's status, R213 had not communicated any needs when NA-D was in the room nor did R213 inform staff she was on the bedpan. When interviewed on 5/27/25 at 10:05 a.m., nurse manager (RN)-A stated she had been in the building morning of 5/4/25, had been informed by RN-C of the incident, went to R213 observed stage one pressure sore (the initial stage of skin breakdown caused by prolonged pressure on a specific area of the body) on R213's buttocks in the outline of the bedpan. RN-A stated had expected the area would progress to a deep tissue injury. RN-A stated R213 used the bed pan or was incontinent, refused to get out of bed to use the bathroom. RN-A reviewed R213's care plan, verified R213's care plan did not identify R213 used the bed pan, care plan stated R213 was incontinent of urine, wore a brief, staff were directed to check and change R213. RN-A stated	F 686			

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F 686	Continued From page 59 did not appear R213 was aware there was a bed pan under her buttocks, R213 had not been herself on 5/3/25, was more fatigued. RN-A had spoken with the involved staff, NA-D had not seen a bed pan under R213, NA-C had fastened brief in place with the bedpan inside the brief. Although the facility failed to ensure R213 received care and services to prevent newly developed pressure ulcers, the facility had immediately assessed R213's skin, and the two NA's were suspended from work. The facility assessed other residents in the facility who used a bedpan or other alternative toileting devices and/or required assistance by staff to be turned and repositioned in bed, the facility completed audits for those identified residents. The facility gave corrective action to NA-C and NA-D, the facility educated nursing staff on what ADL's included, how to read and understand a resident care plan/kardex, how provided cares were documented, how incorrect documentation was avoided, and what neglect of a resident included. The facilities corrective action was verified during the onsite survey on 5/27/25, as having been implemented as of 5/6/25, therefore this deficiency is being cited as Past Non-compliance.	F 686			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689			7/4/25

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F 689	Continued From page 60 This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to comprehensively assess and develop interventions to address falls for 1 of 1 residents (R55) identified to have repeated falls. Findings include: R55's admission minimum data set (MDS) dated 4/10/25, indicated R55 had moderate cognitive impairment and required extensive assistance with activities of daily living (ADLs). R55's fall care area assessment (CAA) dated 4/13/25, indicated R55 had no recent falls. R55 was a fall risk due to wandering behavior, impaired cognition, and was new admission. R55's face sheet printed 5/18/25, indicated R55 had dementia, macular degeneration (progressive eye disease, gradually leads to loss of central vision), repeated falls, congestive heart failure, spinal fusion and difficulty walking. R55's care plan revised 5/2/25, indicated R55 had an actual fall with no injury related to forgetfulness and not wearing proper footwear. Care plan interventions directed staff to ensure R55 was wearing gripper socks if he was not wearing shoes, signage placed on walker to remind resident to use the walker, and staff were directed to complete frequent checks on resident. Review of facility incidents printed 5/20/25, identified R55 had a fall incident on 4/17/25, at 12:46 a.m.; 4/19/25, at 8:50 p.m.; 4/30/25, at 12:00 a.m.; 4/30/25, at 3:30 p.m.; 5/2/25, at 2:20 a.m.; 5/3/25, at 1:35 a.m.; 5/6/25, at 10:30 p.m.;			F 689	F689 Free of Accident Hazards/Supervision/Devices 1. R55 discharged on 6/14/25, unable to updated medical record. 2. All residents with repeat falls have the potential to be affected by deficient practice. Facility will audit residents with repeat falls within the last 90 days, reviewing assessment and interventions are appropriate by 7/4/25. 3. To ensure deficient practice will not recur, facility will reeducate nursing staff regarding Fall policy and procedure including assessment and development of fall interventions. Education will be completed by DNS or Designee by 7/4/25, or prior to next shift. Facility will initiate a review of all residents with falls reviewing proper assessment and fall interventions during morning clinical meeting. Facility will educate clinical leadership team and implement new clinical meeting template process by 7/4/25. 4. To monitor performance and ensure on going compliance, DNS or Designee will audit all residents that have had repeat falls, reviewing for proper assessment and fall intervention weekly x4 monthly x2. The results of those audit findings will be brought to the QAPI Committee meeting by the DNS or designee for further recommendations. 5. Substantial compliance will be achieved by 7/4/25.		

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F 689	Continued From page 61 5/7/25, at 8:30 p.m.; 5/7/25, at 11:30 p.m.; 5/11/25, at 12:00 a.m.; 5/11/25, at 6:20 a.m.; 5/11/25, at 12:00 a.m.; 5/14/25, at 8:45 p.m.; 5/15/25, at 5:05 a.m.; 5/15/25, at 2:00 p.m.; 5/16/25, at 4:50 p.m.; and 5/18/25, at 3:00 a.m. Progress note dated 4/17/25 at 12:51 a.m., indicated R55 was found on the floor, walker was found in the bathroom of his room. Progress note at 1:14 p.m., identified interdisciplinary team (IDT) met to review R55's fall related to self-transfer without walker, did not wear appropriate footwear. IDT placed intervention of gripper socks to decrease risk of similar fall. Progress note dated 4/20/25, at 1:43 a.m. identified R55 was found laying in hallway during 4/19/25 evening medication pass. Progress notes failed to indicate IDT reviewed the fall for root cause of fall or implementation of fall intervention to decrease risk of similar fall from occurring. Review of R55's progress notes failed to identify progress notes regarding falls incident or IDT review of falls for root cause of falls or implementation of interventions to decrease risk of similar fall which occurred on 4/30/25 at 12:00 a.m., and 4/30/25 at 3:30 p.m. Progress note dated 5/2/25 at 3:01 a.m., indicated R55 was found on the floor next to his bed with no injury, forgot to use call light and was unsteady when walking. Progress notes failed to indicate IDT reviewed the fall for root cause of fall or implementation of fall intervention to decrease risk of similar fall from occurring. Progress noted dated 5/3/25 at 4:09 a.m.,	F 689			

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F 689	Continued From page 62 indicated R55 was found sitting on the floor near the bed. Progress notes failed to indicate IDT reviewed the fall for root cause of fall or implementation of fall intervention to decrease risk of similar fall from occurring. Progress note dated 5/6/25 at 11:02 p.m., indicated R55 was found laying on floor next to his bed, R55 was not injured. Progress notes failed to indicate IDT reviewed the fall for root cause of fall or implementation of fall intervention to decrease risk of similar fall from occurring. Progress note dated 5/7/2025 at 9:02 a.m., indicated R2 fell when trying to walk to the bathroom. R2 forgot the walker and was too weak to walk. Progress note at 11:30 p.m., indicated R2 was found on floor next to the bed. Progress notes failed to indicate IDT reviewed the falls for root cause or implementation of fall intervention to decrease risk of similar fall from occurring. Progress note dated 5/8/25 at 4:09 a.m., stated R2 had a fall in the morning at 6:45 a.m., no further information was documented regarding what had occurred. Progress note at 8:30 p.m., indicated R2 was found on the floor next to the bed. Progress notes failed to indicate IDT reviewed the falls for root cause or implementation of fall intervention to decrease risk of similar fall from occurring. Progress note dated 5/11/25 at 12:02 a.m., indicated R2 was found sitting on the bathroom floor in his room. Progress note at 5:47 p.m., indicated R2 was found on the floor at 6:20 a.m. and again at 1:20 p.m. R2 was sent to the hospital after the fall at 1:20 p.m. R2 returned from the hospital on 5/14/25. Discharge	F 689			

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F 689	Continued From page 63 summary indicated R2 had at least 12 falls in the past three days without injury. Progress notes failed to indicate IDT reviewed the falls for root cause or implementation of fall intervention to decrease risk of similar fall from occurring. Progress note dated 5/14/25 at 11:12 p.m., indicated R2 was found sitting on the floor of the bathroom with no injury. Progress notes failed to indicate IDT met to review fall. Progress notes dated 5/15/25 at 5:27 a.m., R2 was found lying on the floor in front of room door. At 3:27 p.m., progress note identified R2 had a fall at 2:00 p.m. There was no further documentation in the progress notes that indicated what occurred. Progress notes failed to indicate IDT reviewed the falls for root cause or implementation of fall intervention to decrease risk of similar fall from occurring. Progress notes dated 5/16/25 at 9:31 a.m., indicated R2 was found on the floor, had attempted to shut bathroom door. Progress note at 4:50 p.m., indicated staff member was monitoring R2 as a 1:1 (individual attention), left R2 who was the found on the floor. Progress notes failed to indicate IDT reviewed the falls for root cause or implementation of fall intervention to decrease risk of similar fall from occurring. Progress note dated 5/17/25 at 11:30 a.m., indicated R2 fell out of wheelchair in the dining room. Progress notes failed to indicate IDT reviewed the fall for root cause or implementation of fall intervention to decrease risk of similar fall from occurring. Progress noted dated 5/19/25 at 9:29 a.m., R2	F 689			

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F 689	Continued From page 64 had a fall in the dining room, was attempting to move wheelchair. Progress notes failed to indicate IDT reviewed the fall for root cause or implementation of fall intervention to decrease risk of similar fall from occurring. When interviewed on 5/20/25 at 5:29 a.m., licensed practical nurse (LPN)-A stated R55 had frequent falls due to being unsteady and impulsive, R55 forgot to use his call light, self-transferred and got self out of bed. During observation on 5/20/25 at 7:15 a.m., R55 was in a transport wheelchair (a type of mobility device specifically designed to be pushed by another person. Unlike standard wheelchairs, which are designed to be propelled by the user, transport wheelchairs have smaller wheels, a narrower frame, and a focus on ease of push and maneuverability by a caregiver or attendant. They are typically used for short trips, outings, and travel, and are not intended for extended use or self-propulsion.) R55 was having difficulty moving the transport wheelchair independently on the unit. During observation on 5/20/25 at 08:19 a.m., R55 was attempting to self-propel transport wheelchair in the hallway. At 12:56 p.m., R55 was observed attempting to self-propel transport wheelchair from the dining room. During observation on 5/27/25 at 9:56 a.m., R55 was sitting in transport wheelchair in his room with a visitor. When interviewed on 5/27/25 at 1:31 p.m., physical therapist (PT)-A stated R55 received physical therapy to increase stability, R55 was not			F 689			

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F 689	Continued From page 65 able to use call light due to cognitive level. R55's transport wheelchair had not been evaluated, the transport wheelchair would need an evaluation by occupational therapy (OT), R55 had no order to be evaluated by OT. PT-A stated R55 was not able to reach breaks on transport wheelchair due to wheels being so small, however if R55 had been in a regular wheelchair automatic locking breaks could be put into place for increased safety. When interviewed on 5/27/25 at 1:49 p.m., nursing assistant (NA)-A stated R55 had always used the transport wheelchair since he admitted to the facility. R55 had many falls, was recently moved to a room closer to the nurses station. When interviewed on 5/27/25 at 2:16 p.m., nurse manager (RN)-A stated falls were reviewed by IDT weekly and every month there was a look back that ensured interventions were effective. Progress notes were to be placed in the medical record for each fall and IDT meeting. RN-A reviewed R55's progress notes, stated was not able to locate notes that indicated R55's fall incidents were consistently reviewed for root cause and new interventions placed to prevent similar falls. RN-A stated R55 used a transport wheelchair, did not know if that was an appropriate chair for R55. Facility Falls Resource Packet-Rehab/Skilled policy dated 4/8/25, identified after a fall check care plan to determine if the cause of the fall was addressed (to avoid additional falls from the same cause). Policy directed if interventions not effective, staff were redirected to revise the care plan. Further the staff were directed to complete post-fall huddle described as an evaluation of a			F 689			

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F 689	Continued From page 66	F 689			
F 732 SS=C	fall by employees from different departments, ideally held where the fall occurred. Post-fall huddles were used to determine cause of the fall and appropriate interventions. Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732			7/4/25

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F 732	Continued From page 67 §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently post the census on the nurse staff posting. This had the potential to affect all 69 residents residing in the facility and/or visitors who may wish to view the information. Findings include: On 5/18/25 at 11:05 a.m., unable to locate a staff posting when arrived at facility. On 5/18/25 at 6:35 p.m., staff posting was observed in a magnetic clip on the metal doorframe of the administration office on first floor. The posting identified nursing staff shifts, census and number of staff assigned each shift. On 5/19/25 at 3:00 p.m., the staff posting with the current date was clipped to the administration office doorframe, clip was positioned about six feet off the floor. On 5/20/25 at 12:28 p.m., the staff posting was positioned on the doorframe about six feet from the floor dated Monday 5/19/25. At 2:15 p.m., the staff posting was updated with current date, continued to be clipped about six feet from the floor. On 5/21/25 at 11:40 a.m., the staff posting was dated 5/20/25, continued to be about six feet from	F 732	F732 Posted Nurse Staffing Information 1. Facility moved Nurse Staff Posting in a more visible area for resident's view on 6/25/25. Nurse Staff Posting updated as of 6/25/25. 2. All residents have the potential to be affected. 3. To ensure deficient practice will not recur, facility will place Nurse staff Posting in a designated wheelchair height location. Educate all licensed nurses regarding Nurse Staff Posting updates by 7/4/25 or prior to next working shift. 4. To monitor performance and ensure on going compliance, DNS or Designee will audit staffing sheets for accuracy weekly x4 monthly x2. The results of those audit findings will be brought to the QAPI Committee meeting by the DNS or designee for further recommendations. 5. Substantial compliance will be achieved by 7/4/25.		

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F 732	Continued From page 68 the floor. At 1:16 p.m., the staff posting was updated with current date, continued to be clipped about six feet from the floor. On 5/27/25 at 9:10 a.m., No staff posting was located on the administration office doorframe. At 11:48 a.m., staff posting with current date was in magnetic clip on administration office doorframe, continued to be about six feet from the floor. When interviewed on 5/27/25 at 1:39 p.m., administrator stated she was responsible for posting the staff posting. Administrator stated the positing was put up about 9:00 am during the week, on weekends the entire weekend was posted. When asked about height of staff posting administrator stated the posting was too high for anyone in a wheelchair to have easy access to read the posting. A facility Nursing Staff Daily Posting Requirements policy dated 12/2/24, indicated the staff posting must be prominently displayed daily in a clear, readable format where residents, staff members andthe public may view.	F 732			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756			7/4/25

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F 756	Continued From page 69 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations for as needed (PRN) anti-psychotic medications were acted upon and addressed in a timely manner for 1 of 5 residents (R43) reviewed for unnecessary medication use. Findings include: In review of R43's Order Summary Report (print	F 756	F756 Drug Regimen Review, Report Irregular, Act On 1. On 5/21/25 the pharmacy consultant's recommendations were immediately communicated for R43 antipsychotic medication to the hospice prescriber. Verbal order was implemented on 5/28/25, per hospice provider's recommendations. 2. Any resident receiving PRN		

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F 756	Continued From page 70 date 5/27/25) indicated the diagnoses of: dementia, visual hallucinations, psychotic disturbance, mood disturbance and anxiety. R43's quarterly Minimum Data Set (MDS), dated 4/17/25, identified R43 had severe cognitive impairment. R43 was admitted to Allina Hospice with the diagnosis of vascular dementia [due to] CVA (cerebral vascular accident - stroke) on 1/29/25, with the orders to use hospice agency standing orders. In review of R43's Order Recap Report (printed 5/20/25) resident was and is receiving Quetiapine Fumarate (and anti-psychotic medication with the following order changes: 3/26/25 Quetiapine Fumarate Oral Tablet 50 milligrams (mg) (Quetiapine Fumarate) Give 100 mg by mouth every 6 hours as needed for agitation or hallucinations. AND Give 50 mg by mouth two times a day for agitation, hallucinations 4/1/25 Quetiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate) Give 25 mg by mouth two times a day for agitation, hallucinations Administer with 50mg. A review of R43's PharmD recommendation (dated 4/14/25) requested the following: "This resident is currently on the anti-psychotic quetiapine 100 mg [every] 6 hours [as needed] with the diagnosis: agitation/hallucinations. Start	F 756	antipsychotic medication has the potential to be affected by deficient practice. By 7/4/25, a review of all residents receiving PRN antipsychotics were reviewed for pharmacy recommendations. 3. To ensure deficient practice will not recur, facility will delegate Drug Regimen Review recommendations to Clinical Care Leaders per assigned units. DNS or Designee will review Pharmacy Recommendations to ensure recommendations were acted on and addressed in a timely manner by 7/4/25. Education will be provided to Clinical Care Leaders by DNS or Designee by 7/4/25. 4. To monitor performance and ensure on going compliance, DNS or designee will audit monthly pharmacy recommendations to ensuring antipsychotic medication recommendations are acted on and addressed in a timely manner, monthly x3. The results of those audit findings will be brought to the QAPI Committee meeting by the DNS or designee for further recommendations. 5. Substantial compliance will be achieved by 7/4/25.		

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F 756	Continued From page 71 3/26/25. Number of times used: 2. *Please add verbiage (times) 14 days for [as needed] anti-psychotic orders* Please evaluate current diagnosis, behavior and usage patterns and evaluate continues need. PRN [as needed] anti-psychotic orders cannot exceed 14 days and require direct prescriber evaluation of continuation." The PharmD noted went on to indicate choices to consider: 1. Discontinue [as needed quetiapine 2. New order for [as needed: _____](include duration (14 days) and rationale) 3. Adjust routine order to _____ A review of R43's electronic medical record (EMR) lacked documentation this recommendation had been reviewed by the prescribing physician. During interview on 5/21/25 at 10:33 a.m., nurse manager (RN)-A stated the facility does not do gradual dose reductions (GDRs) when a resident is receiving hospice services. Those are to be addressed by the hospice nurse / hospice provider. A facility policy, entitled: Psychotropic Medications - Rehab / Skilled (revision date 5/12/25). However, the facility's policy did not address the PRN 14 day limit that was being requested for review by the PharmD. The policy indicated only the following: "Gradual Dose Reduction - The stepwise tapering of a dose to determine whether symptoms, conditions or risks can be managed by a lower	F 756			

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F 756	Continued From page 72 dose or whether the dose or medication can be discontinued." "Gradual Dose Reductions The purpose of tapering medication is to find an optimal dose or to determine if continued use of the medication benefits the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved and/or non-pharmacological interventions have been effective in reducing the symptoms. 1. Antipsychotics a. Within the first year a resident is admitted on an antipsychotic medication or after the location has initiated an antipsychotic medication, the location must attempt a gradual dose reduction (GDR) in two separate quarters with at least one month between attempts, unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. b. Clinically contraindicated means: 1) For a resident who is receiving an antipsychotic medication to treat behavioral symptoms related to dementia, the GDR may be clinically contraindicated if: a) The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the location and b) The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. 2) For a resident receiving an antipsychotic	F 756			

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F 756	Continued From page 73	F 756			
F 757 SS=D	medication to treat a psychiatric disorder, the GDR may be considered contraindicated if: a) The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder; or b) The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the location and the physician has documented the clinical rationale for why any additional attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder." Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757			7/4/25

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F 757	Continued From page 74 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure orthostatic blood pressure monitoring was completed for 1 of 5 residents (R55) reviewed for unnecessary medication use and who consumed antipsychotic medication on a routine basis. In addition, the facility failed to routinely assess residents who received antipsychotic medications for signs and symptoms of tardive dyskinesia (disorder that results in involuntary repetitive body movements) for 1 of 5 residents (R215) reviewed for unnecessary medications. Findings include: R55's admission minimum data set (MDS) dated 4/10/25, identified R55 had moderate cognitive impairment, required extenisve assistance with activities of daily living (ADLs)., and consumed antipsychotic medications on a daily basis. R55's care plan revised 4/18/25, indicated R55 was on antipsychotic medication therapy related to anxiety with interventions of monitor resident condition based on clinical practice guidelines or clinical standards and consult with pharmacy or health care provider to consider dosage reduction when clinically appropriate. R55's order summary dated 5/18/25, indicated R55 had orders for olanzapine (an antipsychotic) 2.5 milligrams (mg) by mouth twice daily for agitation.			F 757	F757 Drug Regimen is Free from Unnecessary Drugs 1. Resident 215 discharged from facility on 5/24/25, unable to make correction to medical record. Resident R55 discharged from facility on 6/14/25, unable to make correction to medical record. 2. All residents on antipsychotic medications have the potential to be affected by deficient practice. Facility will audit all residents on antipsychotic medications for an order for monthly orthostatic BPs and have an updated AIMS with any changes reported as appropriately. This audit will be completed by 7/4/25. 3. To ensure deficient practice will not recur, facility will collaborate with physicians to obtain orders for monthly ortho static BPs for all residents using antipsychotic medication. IDT will monitor completion of AIMS through new clinical meeting template. This will be initiated by 7/4/25. 4. To monitor performance and ensure on going compliance, DNS or designee will audit 100% of residents on antipsychotics for monthly and as needed orthostatic Blood Pressures weekly x4, monthly x2. To monitor performance and ensure on going compliance, DNS or designee will audit for AIMS assessments completion for all residents on		

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F 757	Continued From page 75 R55's medical record was reviewed and lacked evidence of ongoing monitoring set up to ensure R55's orthostatic blood pressure was collected and assessed on a routine, ongoing basis. When observed on 5/19/25 at 3:10 p.m., R55 was asleep in a recliner in his room. When interviewed on 5/20/25 at 5:29 a.m., licensed practical nurse (LPN)-A stated R55 had frequent falls, was unsteady, forgetful and impulsive. When observed on 5/20/25 at 7:15 a.m., R55 was in the hallway attempting to self-propel his wheelchair. When interviewed on 5/27/25 at 2:16 p.m., nurse manager (RN)-A stated orthostatic blood pressure orders should be placed in resident's electronic medical record (EMR) for monthly monitoring when admitted to the facility on an antipsychotic medication or received a new order for an antipsychotic medication. RN-A verified R55's medical record lacked any evidence routine monitoring of R55's orthostatic blood pressures being set up. Further, RN-A stated it was important to ensure orthostatic blood pressures were monitored in someone taking antipsychotic medication to make sure the medication was not "adversely affecting" them. A facility policy on medication management and orthostatic blood pressure monitoring was not provided. R215's admission MDS dated 5/14/25, identified R215 had intact cognition and required moderate	F 757	antipsychotics for monthly and as needed orthostatic Blood Pressures weekly x4, monthly x2. The results of those audit findings will be brought to the QAPI Committee meeting by the DNS or designee for further recommendations. 5. Substantial compliance will be achieved by 7/4/25.		

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F 757	Continued From page 76 assistant with ADLs. R215's diagnoses included hypertension, renal failure, fracture, anxiety disorder and depression. MDS also indicated R215 was receiving dialysis services. R215's physician orders with print date of 5/19/25, indicated R215 had an order for Quetiapine Fumarate (antipsychotic) 50 milligram (mg) once daily for anxiety, restlessness and/or agitation and an order for Quetiapine Fumarate 12.5 mg every six hours as needed for first line for anxiety, restlessness and/or agitation. In review of R215's electronic medical record, no baseline AIMS (abnormal involuntary movement scale) assessment was completed on admission (5/14/25). R215's care plan indicated R215 had the potential for antipsychotic drug adverse reactions related to daily use of antipsychotic medication. During interview on 5/27/25 at 4:30 p.m., registered nurse manager (RN)-A stated nurse managers are responsible for completing the AIMS assessments and they should be completed on admission and every six months if a resident is receiving an antipsychotic medication. RN-A verified R215's baseline AIMS assessment was not completed. RN-A stated it was important for the assessments to be completed to ensure resident was not having any side effects of the antipsychotic medications. The facility Psychotropic Medications policy, dated 5/12/25, identified facility would evaluate behavior interventions and alternatives before using psychotropic medications. The facility would eliminate unnecessary psychotropic medications. Psychotropic drugs include any drug that affects	F 757			

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F 757	Continued From page 77	F 757			
F 880 SS=D	brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: anti-psychotics; anti-depressants; anti-anxiety; and hypnotics. If the physician prescribed an antipsychotic for the resident, a registered nurse must complete the Antipsychotic Medication Assessment and the Abnormal Involuntary Movement Scale in Point Click Care. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880			7/4/25

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F 880	Continued From page 78 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:			F 880			

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F 880	Continued From page 79 Based on observation, interview, and record review the facility failed to ensure proper hand hygiene was performed during dining services for 1 of 1 resident (R1) reviewed for assistance with meal set-up. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/27/25, identified R1 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). R1's diagnoses included hypertension, neurogenic bladder, diabetes mellitus, arthritis, cerebral palsy, epilepsy, atrial fibrillation and depression. During observation on 5/19/25 at 5:14 p.m., nursing assistant (NA)-D assisted R1 with applying ketchup to his bun. NA-D took individual ketchup packets from the middle of the table and removed the top of R1's hamburger bun off, applied ketchup and used the ketchup packet to spread the ketchup around and placed the top bun on pulled pork sandwich. NA-D did not sanitize hands before or after assisting R1 and did not wear gloves. During interview on 5/19/25 at 5:23 p.m., NA-D stated when she helps with meal set-up, she was expected to wear gloves and sanitize hands before and after assisting resident with meal. NA-D confirmed that she did not wear gloves or sanitize hands when assisting R1 and used ketchup packets off the table to spread the ketchup on bun. During interview on 5/27/25 at 3:59 p.m., infection preventionist (IP) stated staff were expected to wash their hands and wear gloves when assisting	F 880	F880 Infection Prevention & Control 1. Facility began hand hygiene education on 6/25/25 regarding performing proper hand hygiene in the dining room for residents requiring assistance with meals and meal set up. 2. All residents have the potential to be affected on deficient practice. 3. To ensure deficient practice will not recur, facility will reeducating all staff regarding performing proper hand hygiene in the dining room for residents requiring assistance with meals and meal set up. Education will be completed by 7/4/25. 4. To monitor performance and ensure on going compliance, DNS or designee will complete observations in the dining room observing staff performing proper hand hygiene in the dining room for residents requiring assistance with meals and meal set up weekly x4, monthly x2. The results of those audit findings will be brought to the QAPI Committee meeting by the DNS or designee for further recommendations. 5. Substantial compliance will be achieved by 7/4/25.		

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F 880	Continued From page 80 residents with meals. RN-A stated it was not appropriate to use ketchup packets to spread ketchup as the packets could have been touched by multiple other people and was an infection control issue. The facility Food Handling policy reviewed 6/25/24, indicated food is handled in a manner that minimizes the risk of contamination. Foods are never touched with bare hands. Proper utensils such as tissue, spatula, tongs, and single-use gloves are used for food handling. Hands are properly washed, and gloves will only be worn when appropriate. All food items are handled appropriately for food safety, including all food prepared for meals and snacks regardless of where the item is served or stored.	F 880			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F 883			7/4/25

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F 883	Continued From page 81 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure recommended pneumococcal vaccinations, as outlined by the			F 883			
					F883 Influenza and Pneumococcal Immunizations 1. R20 and R49 were offered PCV20 by		

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F 883	Continued From page 82 Centers for Disease Control (CDC), were offered and/or provided in a timely manner to reduce the risk of severe disease for 2 of 6 residents (R20 and R49) reviewed for immunizations. Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/2023, identified several tables with corresponding recommendations when to receive various versions (i.e., PPSV23, PCV13, PCV20) of the pneumococcal vaccine. The graph labeled, "Adults [at or older than] 65 years old," outlined persons with a complete series of pneumococcal vaccination (i.e., PCV13 at any age, PPSV23 at or above 65 years old) should have shared clinical decision-making between the resident and healthcare provider to determine if PCV20 was appropriate. R20's admission minimum data set (MDS) dated 4/27/25, identified R20 as having the diagnoses of diabetes, thyroid disorder, anxiety and depression, and was cognitively intact. However, required extensive assistance with activities of daily living. A review of R20's vaccination records noted the following: PVC13 - was given in 2013 PCV23 - had been given twice (2002 and 2017) However, R20's electronic medical record (EMR) lacked evidence resident had been offered and/or given the PCV20. During interview on 5/19/25 at 9:32 a.m., R20			F 883	7/4/25. 2. All resident eligible for PCV20 have the potential to be affected by deficient practice. Facility audit will be completed by 7/4/25 reviewing for all residents eligible and able to be offered PCV20 vaccination identified by 7/4/25. 3. To ensure deficient practice will not recur, facility will initiate a new process of New Admission review during clinical morning meeting as an IDT team including a review of Immunizations eligible and offered. New Clinical Meeting template will be initiated by 7/4/25. 4. To monitor performance and ensure on going compliance, DNS or designee will audit 50% of new admissions for eligibility and offering of PCV20 vaccination weekly x4, monthly x2. The results of those audit findings will be brought to the QAPI Committee meeting by the DNS or designee for further recommendations. 5. Substantial compliance will be achieved by 7/4/25.		

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F 883	Continued From page 83 was unable to remember if the facility had offered and or given her the PVC20 vaccination. In an interview on 5/21/25 at 11:30 a.m., nurse manager (RN)-A, after review of R20's EMR, stated the record lacked evidence the PVC20 vaccination had been offered to the resident. R49's quarterly MDS, dated 4/10/25 listed the diagnoses of coronary artery disease, hypertension, diabetes, and malnutrition and was severely cognitively impaired. A review of R49's vaccination records noted the following: RSV - 10/18/24 PVC13 - 7/31/15 PPSV23 - 5/27/14 However, R49's electronic medical record (EMR) lacked evidence resident had been offered and/or given the PCV20. During interview on 5/18/25 at 7:11 p.m., R49's family member (FAM)-A was unable to remember if the facility had offered and or given her the PVC20 vaccination. In an interview on 5/21/25 at 11:30 a.m., nurse manager (RN)-A, after review of R20's EMR, stated R49 was admitted on 1/15/25, and his record lacked evidence the PVC20 vaccination had been offered to the resident. In review of the facility policy, entitled: Immunizations / Vaccinations for Residents, Pneumococcal, Influenza, COVID-19, Other			F 883			

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F 883	Continued From page 84 [Assisted Living], [Residential Services], [Long Term Care], HBS - Enterprise (last reviewed 11/20/24) indicated the following: "Purpose - - To provide residents and clients the opportunity to receive immunizations as they fit into their healthcare goals. - To provide guidance for the location's immunization program including recommended vaccinations." "Each resident's immunizations will be reviewed upon admission, and on an ongoing basis as immunization recommendations change." "Pneumococcal Vaccinations - It is recommended that all clients and residents receive pneumococcal vaccination(s) per CDC guidelines for eligibility and timing."	F 883			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on May 19, 2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society Waconia and Westview Acres, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/20/2025

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	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The original building was constructed in 1979, is three-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2015 addition is three stories in height, has a partial basement and a tunnel leading to the medical facility, is fully fire sprinkler protected and was determined to be of Type II(111) construction. In April 2016, Floors 2 and 3 have been			K 000			

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

PRINTED: 06/24/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245234	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/19/2025
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE			STREET ADDRESS, CITY, STATE, ZIP CODE 333 FIFTH STREET WEST WACONIA, MN 55387		
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K 000	Continued From page 2 remodeled 14 beds on each floor, and the center core areas on these floors, including the nurse station and related service areas, commons/dining areas, an Oxygen Room, and a neighborhood kitchen with a Denlar hood on each floor. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. All building surveyed as one. The facility has a capacity of 75 beds and had a census of 69 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 225 SS=D	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwells and emergency egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.1, 7.2.1.4.5.1, 19.2.2.3, 7.1.3.2.3, and 7.2.2.5.3. This deficient finding could have a isolated impact on the residents within the facility.	K 225	K225-Stairwells and Smokeproof Enclosures 1) The two chairs on the landing of the stairs used for therapy have been removed. 2) Maintenance and therapy have been educated on the need to keep the stairwell clear of all items on the landing.	7/1/25	

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE			STREET ADDRESS, CITY, STATE, ZIP CODE 333 FIFTH STREET WEST WACONIA, MN 55387		
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K 225	Continued From page 3 Findings include: On 05/19/2025 at 12:09 PM, it was revealed by observation that have two chairs on the landing on the stairs used for therapy. An interview with the Environmental Services Supervisor verified this deficient finding at the time of discovery.	K 225	3) The Maintenance Director/designee will monitor the facility stairwells for any obstructions once weekly for 3 weeks then monthly for 3 months. Non-compliance will be remedied at the time of discovery by the Maintenance Dept. 4) The results of the monitoring will be reported to the Monthly QAPI meeting for review and corrective actions when necessary. 5) Date of Compliance: 7/1		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)	K 321		7/1/25	

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K 321	Continued From page 4 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage room doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 8.7.1.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/19/2025 between 11:41 AM and 12:02 PM, it was revealed by observation patient rooms 362, 317, 216, 227, 262 and 263 are being used for combustible storage and did not have a door closer on the doors. An interview with the Environmental Services Supervisor these deficient findings at the time of discovery.	K 321	K321 Hazardous Areas-Enclosure 1) The items have been removed from the patient rooms 362, 317, 216, 227, 262, and 263. 2) Maintenance has been educated on the regulations on door closure use on storage areas. 3) The Maintenance Director/Designee will monitor the facilities empty rooms for any new items placed in the said rooms once weekly for 3 weeks than monthly for 3 months. Non-compliance will be corrected at time of discovery by the Maintenance Dept. 4) The results of the monitoring will be reported to the Monthly QAPI meeting for review and corrective actions when necessary. 5) Date of Compliance: 7/1		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited	K 324			7/1/25

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K 324	Continued From page 5 cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect their kitchen hood per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.1 and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, sections 4.1.5 and 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/19/2025 at 10:15 AM, it was revealed by a review of available documentation that at the time of the survey, the facility provided a kitchen hood suppression system report dated 04/24/25 and 8/14/2024. The kitchen hood inspections was performed outside on the required semi-annual requirements.			K 324	K324 Cooking Facilities 1) The non-compliance was in the past and cannot be corrected. 2) The Maintenance Dept. has been educated on the need to perform semi-annual hood inspections pre NFPA regulations. 3) The Maintenance Director/Designee will have the Semi-Annual kitchen hood inspections put into the facilities TELS system to ensure timely performance of the inspections. 4) The Administrator/Designee will monitor the TELS system for reminders stating the inspections have not been completed to ensure compliance. The results of the monitoring will be reported to the Monthly QAPI meeting for review and corrective action when necessary.		

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K 324	Continued From page 6	K 324	5) Date of compliance: 7/1		7/1/25
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2 and 5.2.1.2. This deficient finding could have a widespread impact on the residents within the facility.	K 353			

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K 353	Continued From page 7 Findings include: On 05/19/2025 at 10:15 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation for a quarterly sprinkler inspections being completed during the fourth quarter of 2024 and first quarter of 2025. An interview with the Environmental Services Supervisor verified this deficient finding at the time of discovery.	K 353	inspections put into the facilities TELS system to ensure timely performance of the quarterly sprinkler inspections. 4) The Administrator/Designee will monitor the TELS system for reminders stating the inspections have not been completed to ensure compliance. The results of the monitoring will be reported to the Monthly QAPI meeting for review and corrective action when necessary. 5) Date of Compliance: 7/1		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 521	K521 HVAC 1) The non-compliance was in the past and cannot be corrected. 2) The Maintenance Department has been educated on the need to perform inspections on the facilities fire dampers per NFPA 101 regulations. 3) Bids have been obtained and will be approved by our National Campus to perform the inspections and any recommendations by the inspectors.		7/31/25

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K 521	Continued From page 8 On 05/19/2025 at 11:15 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the dampers were inspected since 05/11/2021. An interview with the Environmental Services Supervisor verified this deficient finding at the time of discovery.	K 521	Future inspections will be scheduled per NFPA 101 regulations into the facilities TELS system. 4) The Administrator/Designee monitor the progress of the inspections until completion and monitor the TELS system for future compliance. The results of the monitoring will be reported to the Monthly QAPI meeting for review and corrective action when necessary. 5) Date of Compliance: 7/31		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/19/2025 at 08:40 AM, it was revealed by a	K 712	K712 Fire Drills 1) The non-compliance was in the past and cannot be corrected. 2) The Maintenance Department has been educated on the NFPA regulations regarding fire drills. 3) The Maintenance Director/Designee will enter fire drill schedules per NFPA 101 into the facilities TELS system to ensure compliance.		7/1/25

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K 712	Continued From page 9 review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill had been completed during the First Shift during the fourth Quarter of 2024. An interview with the Environmental Services Supervisor verified this deficient finding at the time of discovery.	K 712	4) The Administrator/Designee will monitor the facilities TELS system for compliance with the fire drill per NFPA 101 regulations. The results of the monitoring will be reported to the Monthly QAPI meeting for review and corrective actions when necessary.		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES)	K 923	5) Date of Compliance: 7/1.	7/1/25	

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K 923	Continued From page 10 STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store oxygen cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5.2 and 11.6.5.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 05/19/2025 at 11:59 AM, it was revealed by observation that the oxygen rooms on the 2nd and 3rd floor did not have full oxygen cylinders segregated from empty oxygen cylinders. An interview with the Environmental Services Supervisor verified this deficient finding at the time of discovery.	K 923	5) Date of Compliance: 7/1. K 923 Gas Equipment 1) The oxygen rooms on the 2nd and 3rd floor have had full oxygen cylinders segregated from empty oxygen cylinders by the Maintenance Department. 2) The Maintenance Department and nursing staff have been educated on the necessity to segregate the empty cylinders from the full cylinders. 3) The Maintenance Director/Designee will inspect the oxygen rooms on the 2nd and 3rd floor for compliance with the NFPA regulations of oxygen cylinders twice per week for 3 weeks than 3 times monthly for compliance. 4) The Administrator will report the results of the inspections to the Monthly QAPI Committee for review and corrective action taken when necessary. 5) Date of Compliance: 7/1		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 20, 2025

Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN 55387

Re: State Nursing Home Licensing Orders
Event ID: GM9011

Dear Administrator:

The above facility was surveyed on May 18, 2025 through May 27, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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

Please feel free to call me with any questions.

Sincerely,



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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00924	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/27/2025
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WACONIA AND			STREET ADDRESS, CITY, STATE, ZIP CODE 333 FIFTH STREET WEST WACONIA, MN 55387		
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/18/25 to 5/27/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/30/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00924	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/27/2025
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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: NO licensing orders were issued. H52344769C (MN00109631). H52344768C (MN00110477). H52344068C (MN00112807) H52344767C (MN00111524) H52344010C (MN00112769) (MN00112536) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be	2 000			

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2 000	Continued From page 2 corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.	2 302			7/4/25

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2 302	Continued From page 3 (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 2 of 8 staff (RN-A and TMA-A) had completed the required Alzheimer's and dementia care training program. This had the potential to affect all residents in the facility that had a Alzheimer's or dementia diagnosis. Findings include: Facility provided training schedule indicated An Overview of Quality Dementia Care was required at general orientation when hired and recurring annually. Nurse manager (RN)-A was identified on facility staff list with hire date of 5/10/22. There was no indication RN-A completed the facility mandatory annual training for Alzheimer and dementia care. Trained medication aid (TMA)-A was identified on facility staff list with hire date of 4/19/21. There was no indication RN-A completed the facility mandatory annual training for Alzheimer and dementia care. When interviewed on 5/20/25 at 5:06 a.m., nursing assistant (NA)-B stated dementia training was done when first hired and yearly on the computer When interviewed on 5/20/25 at 5:29 a.m., licensed practical nurse (LPN)-A dementia training was done on the computer, completed	2 302	Corrected		

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2 302	Continued From page 4 when first hired then at least annually. Alzheimer's and dementia care training policy was requested, however, none was provided. SUGGESTED METHOD: The administrator or designee could develop/revise and implement policies and procedures and provide training related to the required Alzheimer's training program requirements, including who must have the training and what the content of the training must include. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302			
2 530	MN Rule 4658.0300 Subp. 4 Use of Restraints Subp. 4. Decision to apply restraint. The decision to apply a restraint must be based on the comprehensive resident assessment. The least restrictive restraint must be used and incorporated into the comprehensive plan of care. The comprehensive plan of care must allow for progressive removal or the progressive use of less restrictive means. A nursing home must obtain an informed consent for a resident placed in a physical or chemical restraint. A physician's order must be obtained for a physical or chemical restraint which specifies the duration and circumstances under which the restraint is to be used, including the monitoring interval. Nothing in this part requires a resident to be awakened during the resident's normal sleeping hours strictly for the purpose of releasing restraints. This MN Requirement is not met as evidenced	2 530			7/4/25

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2 530	Continued From page 5 by: Based on observation, interview and document review, the facility failed to ensure pillows were not used in a manner to restrain residents while in bed for 1 of 1 resident (R21) reviewed for restraints. Findings include: R21's admission Minimum Data Set (MDS) dated 3/23/25, identified R21 had moderate cognitive impairment and diagnoses of dementia, Parkinson's, seizure disorder and depression. MDS also indicated R21 did not use any restraints. R21's care plan reviewed 5/27/25, identified R21 had limited physical mobility and was a fall risk related to confusion and restlessness. Staff were directed to assist R21 from lying to sitting and from sitting to lying with an assist of one to help guide lower extremities and to assist R21 with an assist of two for sit to stand for all transfer. R21 used a fall mat next to his bed. R21's care plan did not identify the use of pillows under his fitted sheet to prevent R21 from crawling out of bed. During an observation on 5/18/25 at 5:20 p.m., R21 was lying on his back in the middle of his bed with his blankets covering to his chest. On R21's right side two pillows were tucked under the fitted sheet and ran along R21's body from his shoulders to his knees. R21's bed was in low position with a fall mat next to his bed. During an observation on 5/19/25 at 3:07 p.m., R21 was lying on his back in the middle of his bed with his blankets covering to his chest. On R21's right side two pillows were tucked under the fitted sheet and ran along R21's body from his	2 530	Corrected		

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2 530	Continued From page 6 shoulders to his knees. R21's bed was in low position with a fall mat next to his bed. During an observation on 5/20/25 4:49 a.m., R21 was lying on his back in the middle of his bed with his blankets covering to his chest. On R21's right side two pillows were tucked under the fitted sheet and ran along R21's body from his shoulders to his knees. R21's bed was in low position with a fall mat next to his bed. During an observation on 5/20/25 8:15 a.m., R21 was lying on his back in the middle of his bed with his blankets covering to his chest. R21's eyes were open with him looking around his room. On R21's right side two pillows were tucked under the fitted sheet and ran along R21's body from his shoulders to his knees. R21's bed was in low position with a fall mat next to his bed. During interview on 5/20/25 at 5:21 a.m., registered nurse (RN)-F stated R21 did not like to get up and that he needed assistance to get out of bed. RN-F stated R21 was a fall risk and that was the reason why the pillow was tucked in under the bottom sheet that ran along R21's body. RN-F stated the pillow stops him from getting out of the bed, the pillows have been used for "awhile". During interview on 5/20/25 at 12:55 p.m., trained medication aide (TMA)-A stated R21 attempted to get out of bed by himself. TMA-A stated R21's pillows were underneath the fitted sheet so R21 could not get out of bed, "we do it all the time." TMA-A stated she did not know if R21 could remove the pillows if R21 wanted to. During interview on 5/20/25 at 1:04 p.m., nursing assistant (NA)-F stated R21 was a fall risk and a	2 530			

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2 530	Continued From page 7 pillow was placed along his right side at all times so R21 couldn't get out of bed. NA-F stated she did not know if R21 could remove the pillows if R21 wanted to. During interview on 5/27/25 at 3:55 pm., RN-A stated resident could not get out of bed by himself and staff have to assist him with transfers. RN-A stated R21 liked to sit up on the edge of the bed but was not strong enough to stand up. RN-A confirmed there was no physical restraint assessment completed for R21 as she was not aware of staff utilizing pillows along R21's side. RN-A stated pillows should not be placed under the sheet as it could be considered a restraint. RN-A stated she would have to assess R21 to see if he could remove the pillow by himself. RN-A stated she would expect staff to update her if they are utilizing pillows in this manner. The facility Restraints policy, dated 10/29/24, indicated resident are free from any physical or chemical restrains imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. When the use of restraints is indicated, the location must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Anytime a device, material or equipment is attached or placed adjacent to the resident's body, a determination will be made by a licensed nurse as to whether it is or could be a restrain for the individual resident and a Physical Device and/or Restraint Evaluation and Review is completed by a licensed nurse. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and/or revise policies to ensure restraints are based on a comprehensive resident	2 530			

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2 530	Continued From page 8 assessment prior to initiation, with the least restrictive restraint used and incorporated into the plan of care. The DON or designee should review other residents at risk or who have restraints applied and ensure the physician order obtained for a physical or chemical restraint specifies the duration and circumstances under which the restraint is to be used, including the monitoring interval. The DON or designee should educate staff to policies and procedures and perform measurable audits for restraint use to ensure all measures are followed. The results of those audits should be taken to QAPI to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 530			
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with the potential for inaccurate federal reimbursement and resident care planning for 2 of 2 residents (R49 and R59) reviewed for MDS accuracy. Findings include:	2 550	Corrected	7/4/25	

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2 550	Continued From page 9 R49's quarterly MDS dated 4/10/25, indicated under "Section J" (J1700-B) Falls documented R49 did not have any falls since the last MDS Assessment (Admission MDS, submitted 1/14/25). In review of R49's electronic medical record (EMR), it was noted R49 had two falls since admission: 2/2/25 - R49 rolled out of bed and onto the floor 2/4/25 - R49 self transferred from wheel chair and fell to the floor During an interview on 5/21/25 at 10:33 a.m., nurse manager (RN)-A and interim director of nursing (DON)-A stated R49's two falls should have been documented on the 4/10/25 quarterly MDS. R59's Discharge Return Not Anticipated MDS submission dated 3/6/25, indicated under "Section A" (A2105) Discharge Status documented R59 was discharge to :Short-Term General Hospital." In review of R59's electronic medical record (EMR), documented the following in R59's progress notes: "3/6/2025 [1:33 p.m.] Discharge -Home, Assisted Living, Other Facility, Involuntary Destination: Home Method of transportation and who accompanied resident, included their relationship to resident: daughter and son in law transported resident home via own vehicle at [12:30 p.m.]. Medications reviewed. Notes: 1 card of 28 tramadol [tablets] and own bottle of tramadol 7 [tablets] sent home with resident."	2 550			

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2 550	Continued From page 10 During an interview on 5/21/25 at 10:33 a.m., nurse manager (RN)-A and interim director of nursing (DON)-A, RN-A stated the discharge MDS submission was coded incorrectly. and verified R59 had discharged to home. A facility' policy on MDS completion was requested, however, none was received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure policies are up to date, staff training has been completed, implemented and monitored to assure quarterly minimum data set (MDS) are completed accurately and timely. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550			
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative.	2 555			7/4/25

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2 555	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed, accurate, and revised to assure assessed care needs were implemented for 1 of 2 residents (R35) reviewed for dialysis. Findings include: R35's admission Minimum Data Set (MDS) dated 4/21/25, identified R35 had intact cognition and required assistance with all activities of daily living (ADLs). R35's diagnoses included end stage renal disease, heart failure, hypertension, cirrhosis, diabetes mellitus, arthritis, depression, dependence on renal dialysis, and chronic pain. R35's physician orders, print date of 5/21/25, indicated an order for dialysis on Monday/Wednesday/Friday at Fresenius Waconia with a start date of 4/15/25. R35's care plan, print date of 5/21/25, failed to include dialysis including goals of treatment, and interventions allowing the nurse to assess the intervention's outcome and potentially revise care based on the resident's status. During interview on 5/27/25 at 3:49 p.m., registered nurse manager (RN) stated the nurse managers are responsible for updating the resident's care plans. RN-A stated if a resident was receiving dialysis, it should be included in the care plan so staff are watching for signs and symptoms and could recognize problems earlier to treat sooner. RN-A stated it was important to include dialysis on the care plan to help with	2 555	Corrected		

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2 555	Continued From page 12 implementation of interventions or staff being aware so symptoms could be recognized and acted on. RN-A confirmed R35's care plan did not include that R35 was receiving dialysis services nor was there any dialysis goals/interventions related to care for dialysis patients. The facility Comprehensive Care Plan facility, dated 1/31/25, indicated facility would develop a person-centered care plan for each resident that includes measurable objectives and timetables to meet his or her physical, mental, spiritual and psychosocial well-being. The facility would provide an ongoing method of assessing, implementing, evaluating and updating the resident's care plan to help maintain the resident's highest practicable level of function, including culturally competent and trauma informed care. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure policies are up to date, staff training has been completed, implemented and monitored to assure quarterly minimum data set (MDS) are completed accurately and timely. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555			
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	2 570			7/4/25

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2 570	Continued From page 13 disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan to include current behaviors for 1 of 1 residents (R51), toileting needs for 1 of 1 residents (R20), discontinued medications for 1 of 1 residents (R24), resident receiving tube feedings for 1 of 1 residents (R7), and falls for 1 of 1 residents (R55) in the sample whose care plans were reviewed. Findings include: R51's Face Sheet printed 5/27/25, indicated the diagnoses of Alzheimer's disease, dementia with behavioral disturbances, anxiety disorder, restlessness and agitation. R51's admission minimum data set (MDS) dated 2/27/25, identified R50 was cognitively impaired and required extensive assistance with activities of daily living. During observation and interview on 5/18/25 at 4:24 p.m., it was observed that R51 had long finger nails on all fingers and thumbs. Some of which were 1/4 inched in length. R51 was also noted to have been unshaven, noting a rechargeable razor on resident's bed. R51 stated, "I was meaning to cut them (finger nails)." R51 stated he had just completed his shaving.	2 570	Corrected		

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2 570	Continued From page 14 General observations throughout each day (5/19/25 and 5/20/25), noted no change in R51's nail length nor shaving. An interview on 5/20/25 at 11:57 a.m., nursing assistant (NA)-A stated R51 was independent with his cares, with reminders for clean clothes and showering in his room. NA-A stated R51 refused to have staff assist with his care. NA-A stated staff have tried to shave and trim R51's nails, but he would not allow. NA-A stated residents' nails are usually trimmed on bath days. During an interview on 5/20/25 at 1:01 p.m., the bath aid - trained medication assistant (TMA)-A stated R51's bath day (shower) is scheduled for Thursdays. TMA-A stated R51 will not allow staff to assist with his shower, however, she frequently checked on this due to his confusion, becomes easily distracted 1/2 way through and does not complete the task. She has not been able to trim his nails or shave him, as he stated he is able to. In review of the R51's assessment, Functional Abilities and Goals - Admission/Start of Skilled Care Complete Admission, dated 2/22/2025, the following was documented: - Self Care - Needed Some Help - Resident needed partial assistance from another person to complete activities. - Functional Cognition - Needed Some Help - Resident needed partial assistance from another person to complete activities - Personal Hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). - Admission Performance - Substantial/maximal assistance	2 570			

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2 570	Continued From page 15 In review of R51's care plan, the document lacked both resident's needs in care provision, as well as resident's behavior of care assistance refusal. In an interview on 5/21/25 at 11:03 a.m., nurse manager (RN)-A stated R51 is not independent with his cares and needs set up, cues and reminders. RN-A stated 51's care plan is lacking residents behavior to complete and/or allow staff to assist with his care. RN-A stated this will need further assessment and input from resident family and facility staff. R20's Clinical Physicians Orders, printed 5/27/25, indicated R20's main diagnosis was "other mechanical complication of implanted electronic neurostimulator of spinal cord electrode (lead)." R20's admission MDS dated 4/27/25, identified R20 was cognitively intact and required extensive assistance with activities of daily living, including toileting During an interview on 05/19/25 at 9:16 a.m., R20 stated since her back surgery, she has needed a lot of help with her toileting, and was especially concerned about her bowels not being regulated appropriately. In review of R20's Functional Abilities - Current Performance assessment dated 5/13/25, indicated R20 required "supervision or touching assistance" with toileting. In an interview on 5/21/25 at 9:11 a.m., registered nurse (RN)-B stated R20 has had ongoing issues with bowel movements, more so, not wanting to be toileted. RN-B stated R20 had been refusing	2 570			

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2 570	Continued From page 16 to be toileted and or have her incontinence brief changed, regardless if she was incontinent of urine or stool. RN-B stated she made an agreement with R20 that staff would be allowed to check and change R20, and provide peri-care at that time, shiftly. Review of R20's Care Plan last revised 5/2/25, lacked information on R20's toileting needs and the assistance needed to be provided. During interview on 5/21/25 at 11:09 a.m., RN-A stated R20 should have had toileting needs and interventions added to her care plan. R24's Order Recap Report, printed 5/20/25, indicated the diagnoses of malignant neoplasm of breast, with lumps / masses of head and neck, anxiety disorder and changes in cognitive function. R24 was receiving hospice services. R24's significant change minimum data set (MDS) dated 3/6/25, identified R50 was severely cognitively impaired and required extensive assistance with activities of daily living. R24's anastrozole was discontinued on 2/24/25. R24 was admitted to Ridgeview Hospice for comfort cares on 2/26/25. In review of R24's Care Plan last revised 4/14/25, the following care plan concern was documented: - "The resident has an alteration in hematological (related to the study of blood and blood-forming tissues, including the bone marrow, spleen, and lymph nodes) status [related to] [history of] breast cancer {and the] use of anastrozole (is a nonsteroidal aromatase inhibitor used in the treatment of breast cancer)."	2 570			

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2 570	Continued From page 17 During interview on 5/21/25 at 11:00 a.m., RN-A stated R24's anastrozole was discontinued, after having a discussion with residents family, when R20 enrolled into hospice services. The anastrozole was not a covered medication while on hospice. RN-A stated R24's care plan should have been updated. R7 R7's quarterly MDS dated 3/6/25, indicated R7 was cognitively intact, was independent with activities of daily living (ADLs) and had a feeding tube. R7's face sheet printed 5/18/25, indicated R7 had diagnoses of dysphagia (difficulty swallowing), gastrostomy status (opening into the stomach from the abdominal wall, made surgically for the introduction of food.) gastro-esophageal reflux disease (GERD), and hypertension. R7's care plan last revised 11/17/24, indicated R7 had a self-care deficit related to tube feeding with an intervention of nothing by mouth (NPO) - tube feeding. Care plan also indicated R7 required tube feeding related to dysphagia with and intervention of no water pitcher at bedside due to NPO status. On 1/10/25, R7 received a new order for regular diet, regular texture, with thin liquids. Resident desired regular diet for quality of life. Okay to provide any food items per resident request. However, R7's care plan was not updated regarding change in NPO status. When interviewed on 5/18/25 at 5:11p.m., R7 stated he ate food for pleasure, tended to request easy to swallow foods like scrambled eggs and	2 570			

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2 570	Continued From page 18 mashed potatoes. R7 hoped to increase his oral intake and eventually have the tube feeding removed. When interviewed on 5/21/25 at 11:15 a.m., nurse manager (RN)-A stated care plans were to be updated by the nurse manager as soon as they were notified of a change or during the next assessment period. RN-A stated R7's care plan should have been updated when diet order was changed in January 2025, diet change on care plan was also not completed during assessment period for quarterly MDS in March 2025. R55 R55's admission MDS dated 4/10/25, indicated R55 had moderate cognitive impairment and required extensive assistance with ADL's. R55's face sheet printed 5/18/25, indicated R55 had diagnoses of dementia, neurocognitive disorder with Lewy bodies (a progressive brain disorder characterized by cognitive decline, fluctuating alertness, visual hallucinations, and Parkinsonism symptoms), age-related macular degeneration, difficulty walking and repeated falls. R55's fall care area assessment (CAA) dated 4/13/25, identified R55 had no recent falls, was at risk for falls related to wandering behavior, impaired cognition, and new admission. R55's care plan last revised 5/2/25, indicated R55 had an actual fall related to forgetfulness and not wearing proper footwear. With interventions which required staff to ensure R55 wore gripper socks if shoes not worn dated 4/17/25; sign connected to walker with reminder to bring walker with dated 4/24/25; and staff to complete frequent	2 570			

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2 570	Continued From page 19 checks on resident throughout the day dated 5/2/25. However, there was no indication the fall care plan or interventions were updated regarding R55's frequent falls. R55 admitted to the facility on 4/4/25. Review of progress notes and incident indicated R55 had 18 or more falls since he was admitted to the facility. R55 was sent to the emergency room on 5/11/25 due to repeated falls, hospital discharge summary dated 5/14/25 indicated R55 had fallen at least 12 times in the past three days without injury. When interviewed on 5/27/25, at 4:06 p.m. RN-A stated she had reviewed R55's care plan but was unable to speak to why the care plan had not been updated regarding frequent falls or any interventions that may have been changed due to the other nurse manager that was responsible for the unit R55 resided on was no longer employed at the facility. The expectation was the care plan should have been updated when falls were reviewed, and new interventions were put into place. A facility Comprehensive Care Plan and Care Conferences- Rehab/Skilled, Therapy and Rehab policy dated 1/31/25, indicated the purpose to provide an ongoing method of assessing, implementing, evaluating and updating the residents care plan to help maintain the residents highest practicable level of function. The policy directs care plans to be reviewed and revised with each MDS completed, in addition care plans must be revised as the residents needs or status changed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could	2 570			

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2 570	Continued From page 20 inservice nursing staff related to timely and accurate development of the care plan; then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570			
2 875	MN Rule 4658.0520 Subp. 2 I Adequate and Proper Nursing Care; Monitor TPR Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure as needed (PRN) medications were administered per physician's order for 1 of 1 resident (R20) reviewed for edema. Findings include: R41's admission Minimum Data Set (MDS) dated 5/1/25, identified R41 had moderate cognitive impairment and required assistance with activities of daily living (ADL)'s. R41's diagnoses included acute on chronic systolic (Congestive) heart failure, atrial fibrillation, coronary artery disease, heart failure, hypertension, renal failure, localized edema, presence of prosthetic heart valve, and presence of coronary angioplasty implant and graft	2 875	Corrected	7/4/25	

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2 875	Continued From page 21 R41's physician orders with print date of 5/19/25, indicated R41 had an order for daily weights in the morning for heart failure with reduced ejection fraction (HFrEF) and to update physician assistant (PA) or medical doctor (MD) if increased of three pounds in a day or five pounds in a week. R41 also had an order for Torsemide 20 milligrams (mg) as needed (PRN) for HFrEF daily if weight exceeds 116.0 pounds with a start date of 5/13/25. During review of R41's electronic health record (EHR), noted EHR lacked documentation of administration of PRN medication on 5/13/25, 5/14/25, 5/15/25, 5/16/25, 5/17/25, 5/18/25 and 5/19/25 when it was noted R41's weight exceeded 116.0 pounds. R41's weight documentation, in EHR, indicated increased weight gain overnight on the following dates: -5/13/25 at 8:20 a.m., weight was documented as 116.6 lbs. (pounds) - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. -5/14/25 at 8:48 a.m., weight was documented as 116.2 lbs. - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. -5/15/25 at 9:06 a.m., weight was documented as 116.8 lbs. - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. -5/16/25 at 1:20 p.m., weight was documented as 117.8 lbs. - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. -5/17/25 at 12:21 p.m., weight was documented as 118.8 lbs. - based on order PRN torsemide	2 875			

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2 875	Continued From page 22 should have been administered due to weight gain over 116.0 lbs. -5/18/25 at 9:28 a.m., weight was documented as 116.8 lbs. - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. -5/19/25 at 10:33 a.m., weight was documented as 117.2 lbs. - based on order PRN torsemide should have been administered due to weight gain over 116.0 lbs. R41's progress notes lacked documentation of increased weight and indicated: - 5/12/25 indicated R41 had an appointment at Minneapolis Heart and orders were changed for Torsemide as needed order to once daily as needed for weight excess of 116 pounds and an order for compression stockings to bilateral lower extremities daily for edema. - 5/19/25 at 11:19 p.m., indicated R41 was sent to the emergency department for low oxygen saturations of 84% and complaints of shortness of breath. - 5/20/25 indicated R41 was hospitalized with pneumonia and fluid overload. R41's electronic medical administration record (MAR) lacked documentation of administration of as needed Torsemide as ordered by cardiologist. During observation on 5/18/25 at 3:17 p.m., R41 had 2+ pitting edema noted in his bilateral lower extremities. During observation and interview on 5/19/25 at 3:30 p.m., R41 was seated in a wheelchair in his room with oxygen on flowing at two liters per minute via nasal cannula, which he did not have on previously. R41 had edema noted in his bilateral lower extremities. R41 stated he had a	2 875			

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2 875	Continued From page 23 dry cough and stuffy nose that started on 5/19/25 and it was harder for him to breath today. During interview on 5/20/25 at 8:10 a.m., registered nurse (RN)-E stated R41 was sent to the ER on 5/19/25 in the evening. RN-E stated R41 had low oxygen saturations all day on 5/19/25 with his breathing getting worse as the day went on. RN-E updated provider and obtained an order for a chest x-ray to be completed and an order for Mucinex. RN-E stated R41 had daily weights due to his diagnoses of congestive heart failure and there were no parameters of prn orders related to daily weights. RN-E stated R41 had edema and his scheduled torsemide order was increased approximately a week and a half ago. RN-E reviewed R41's orders and stated "oh, there is a prn order of torsemide." RN-E confirmed R41 should have received the prn dose of torsemide for the past seven days due to his weights being above 116.0. RN-E stated R41's increased shortness of breath could have been caused by not receiving the prn dose of torsemide as ordered. During interview on 5/20/25 at 11:02 a.m., R41's primary physician stated R41 had a history of congestive heart failure and was a very high-risk patient due his CHF. Physician stated the prn order of Torsemide was ordered by R41's cardiologist but he would expect the facility to administer medication as ordered. Physician stated he saw R41 the morning of 5/19/25 with R41 having crackles in lower lobes and localized edema in bilateral lower extremities. Physician stated he ordered a chest x-ray to be obtained as R41 can go into an acute exacerbation very quickly and can decompensate at any time. During interview on 5/21/25 at 8:41 a.m., health	2 875			

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2 875	Continued From page 24 unit coordinator (HUC) stated she was responsible for processing and entering new orders and once entered it would be checked by a nurse. HUC stated PRN orders are added to the existing scheduled orders and should pop up for nursing on the MAR. During interview on 5/21/25 at 8:25 a.m., licensed practical nurse (LPN)- B stated R41 had orders for daily weights to be completed and there were no parameters of prn orders related to daily weights. During interview on 05/21/2025 at 11:29 a.m., registered nurse manager (RN)-A stated orders are processed by the HUC and a nurse would double check the order. RN-A stated if resident had a scheduled dose of ordered medication, the prn order would be added to the scheduled dose. RN-A stated the parameters for the prn dose would be displayed on the bottom on the EMAR (electronic medication administration record). RN-A reviewed R41's EMAR and stated nursing would not have seen the prn order with the way it was entered. Nursing would have to go into the PRN tab to see if R41 had a PRN dosage. The prn order should have been entered as a separate order or with the daily weights, so staff were aware of available medication. RN-A reviewed R41's weights and stated R41 should have received seven doses of prn torsemide in the past seven days as weight was over 116.0. RN-A stated R41 was hospitalized for shortness of breath and fluid on his lungs and the prn dose could have made a difference with managing his symptoms. Attempted to contact R41's prescribing cardiologist on 5/20/25 at 12:27 p.m., 5/21/25 at 9:59 a.m., and again on 5/21/25 at 2:08 p.m. with	2 875			

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2 875	Continued From page 25 no success. The facility Medication Administration policy, dated 4/8/25, indicated the facility would promote resident/family understanding of medication therapy, would administer medications correctly and in a timely manner and would schedule medications effectively. When PRN medications are given, facility would evaluate and document the efficacy of the medication. If using non-licensed personnel to dispense medications, the follow-up should be done by a licensed nurse. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review relevant policies and procedures, inservice staff; then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 875			
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure proper hand hygiene was performed during dining services for 1 of 1 resident (R1) reviewed for assistance with meal set-up.	21385	Corrected	7/4/25	

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WACONIA AND			STREET ADDRESS, CITY, STATE, ZIP CODE 333 FIFTH STREET WEST WACONIA, MN 55387		
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21385	Continued From page 26 Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/27/25, identified R1 had moderate cognitive impairment and required assistance with all activities of daily living (ADLs). R1's diagnoses included hypertension, neurogenic bladder, diabetes mellitus, arthritis, cerebral palsy, epilepsy, atrial fibrillation and depression. During observation on 5/19/25 at 5:14 p.m., nursing assistant (NA)-D assisted R1 with applying ketchup to his bun. NA-D took individual ketchup packets from the middle of the table and removed the top of R1's hamburger bun off, applied ketchup and used the ketchup packet to spread the ketchup around and placed the top bun on pulled pork sandwich. NA-D did not sanitize hands before or after assisting R1 and did not wear gloves. During interview on 5/19/25 at 5:23 p.m., NA-D stated when she helps with meal set-up, she was expected to wear gloves and sanitize hands before and after assisting resident with meal. NA-D confirmed that she did not wear gloves or sanitize hands when assisting R1 and used ketchup packets off the table to spread the ketchup on bun. During interview on 5/27/25 at 3:59 p.m., infection preventionist (IP) stated staff were expected to wash their hands and wear gloves when assisting residents with meals. RN-A stated it was not appropriate to use ketchup packets to spread ketchup as the packets could have been touched by multiple other people and was an infection control issue.	21385			

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21385	Continued From page 27 The facility Food Handling policy reviewed 6/25/24, indicated food is handled in a manner that minimizes the risk of contamination. Foods are never touched with bare hands. Proper utensils such as tissue, spatula, tongs, and single-use gloves are used for food handling. Hands are properly washed, and gloves will only be worn when appropriate. All food items are handled appropriately for food safety, including all food prepared for meals and snacks regardless of where the item is served or stored. SUGGESTED METHOD OF CORRECTION: The Infection Control Preventionist (ICP) or designee could review facility policies/procedures regarding appropriate infection control technique during meals. The ICP or designee could provide staff education regarding the policies and educate staff on appropriate IC technique while assisting residents at mealtimes. The ICP or designee should complete timely audits to ensure policies are being followed to ensure on-going competence. The ICP, or designee should take education verifications and the audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: 21 (twenty-one) DAYS	21385			
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service	21530			7/4/25

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21530	Continued From page 28 Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations for as needed (PRN) anti-psychotic medications were acted upon and	21530	Corrected		

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21530	Continued From page 29 addressed in a timely manner for 1 of 5 residents (R43) reviewed for unnecessary medication use. Findings include: In review of R43's Order Summary Report (print date 5/27/25) indicated the diagnoses of: dementia, visual hallucinations, psychotic disturbance, mood disturbance and anxiety. R43's quarterly Minimum Data Set (MDS), dated 4/17/25, identified R43 had severe cognitive impairment. R43 was admitted to Allina Hospice with the diagnosis of vascular dementia [due to] CVA (cerebral vascular accident - stroke) on 1/29/25, with the orders to use hospice agency standing orders. In review of R43's Order Recap Report (printed 5/20/25) resident was and is receiving Quetiapine Fumarate (and anti-psychotic medication with the following order changes: 3/26/25 Quetiapine Fumarate Oral Tablet 50 milligrams (mg) (Quetiapine Fumarate) Give 100 mg by mouth every 6 hours as needed for agitation or hallucinations. AND Give 50 mg by mouth two times a day for agitation, hallucinations 4/1/25 Quetiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate) Give 25 mg by mouth two times a day for agitation, hallucinations Administer with 50mg. A review of R43's PharmD recommendation	21530			

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21530	Continued From page 30 (dated 4/14/25) requested the following: "This resident is currently on the anti-psychotic quetiapine 100 mg [every] 6 hours [as needed] with the diagnosis: agitation/hallucinations. Start 3/26/26. Number of times used: 2. *Please add verbiage (times) 14 days for [as needed] anti-psychotic orders* Please evaluate current diagnosis, behavior and usage patterns and evaluate continues need. PRN [as needed] anti-psychotic orders cannot exceed 14 days and require direct prescriber evaluation of continuation." The PharmD noted went on to indicate choices to consider: 1. Discontinue [as needed quetiapine 2. New order for [as needed: _____](include duration (14 days) and rationale) 3. Adjust routine order to _____ A review of R43's electronic medical record (EMR) lacked documentation this recommendation had been reviewed by the prescribing physician. During interview on 5/21/25 at 10:33 a.m., nurse manager (RN)-A stated the facility does not do gradual dose reductions (GDRs) when a resident is receiving hospice services. Those are to be addressed by the hospice nurse / hospice provider. A facility policy, entitled: Psychotropic Medications - Rehab / Skilled (revision date 5/12/25). However, the facility's policy did not address the PRN 14 day limit that was being requested for review by the PharmD. The policy indicated only the following:	21530			

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21530	Continued From page 31 "Gradual Dose Reduction - The stepwise tapering of a dose to determine whether symptoms, conditions or risks can be managed by a lower dose or whether the dose or medication can be discontinued." "Gradual Dose Reductions The purpose of tapering medication is to find an optimal dose or to determine if continued use of the medication benefits the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved and/or non-pharmacological interventions have been effective in reducing the symptoms. 1. Antipsychotics a. Within the first year a resident is admitted on an antipsychotic medication or after the location has initiated an antipsychotic medication, the location must attempt a gradual dose reduction (GDR) in two separate quarters with at least one month between attempts, unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. b. Clinically contraindicated means: 1) For a resident who is receiving an antipsychotic medication to treat behavioral symptoms related to dementia, the GDR may be clinically contraindicated if: a) The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the location and b) The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed	21530			

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21530	Continued From page 32 behavior. 2) For a resident receiving an antipsychotic medication to treat a psychiatric disorder, the GDR may be considered contraindicated if: a) The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder; or b) The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the location and the physician has documented the clinical rationale for why any additional attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review applicable procedures and policies to ensure the timely acting upon pharmacist recommendations; the educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530			
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:	21535			7/4/25

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21535	Continued From page 33 A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure orthostatic blood pressure monitoring was completed for 1 of 5 residents (R55) reviewed for unnecessary medication use and who consumed antipsychotic medication on a routine basis. In addition, the facility failed to routinely assess residents who received antipsychotic medications for signs and symptoms of tardive dyskinesia (disorder that results in involuntary repetitive body movements) for 1 of 5 residents (R215) reviewed for unnecessary medications. Findings include: R55's admission minimum data set (MDS) dated	21535	Corrected		

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21535	Continued From page 34 4/10/25, identified R55 had moderate cognitive impairment, required extenisve assistance with activities of daily living (ADLs)., and consumed antipsychotic medications on a daily basis. R55's care plan revised 4/18/25, indicated R55 was on antipsychotic medication therapy related to anxiety with interventions of monitor resident condition based on clinical practice guidelines or clinical standards and consult with pharmacy or health care provider to consider dosage reduction when clinically appropriate. R55's order summary dated 5/18/25, indicated R55 had orders for olanzapine (an antipsychotic) 2.5 milligrams (mg) by mouth twice daily for agitation. R55's medical record was reviewed and lacked evidence of ongoing monitoring set up to ensure R55's orthostatic blood pressure was collected and assessed on a routine, ongoing basis. When observed on 5/19/25 at 3:10 p.m., R55 was alseep in a recliner in his room. When interviewed on 5/20/25 at 5:29 a.m., licensed practical nurse (LPN)-A stated R55 had frequent falls, was unsteady, forgetful and impulsive. When observed on 5/20/25 at 7:15 a.m., R55 was in tha hallway attempting to self-propel his wheelchair. When interviewed on 5/27/25 at 2:16 p.m., nurse manager (RN)-A stated orthostatic blood pressure orders should be placed in resident's electronic medical record (EMR) for monthly monitoring when admitted to the facility on an	21535			

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21535	Continued From page 35 antipsychotic medication or received a new order for an antipsychotic medication. RN-A verified R55's medical record lacked any evidence routine monitoring of R55's orthostatic blood pressures being set up. Further, RN-A stated it was important to ensure orthostatic blood pressures were monitored in someone taking antipsychotic medication to make sure the medication was not "adversely affecting" them. A facility policy on medication management and orthostatic blood pressure monitoring was not provided. R215's admission MDS dated 5/14/25, identified R215 had intact cognition and required moderate assistant with ADLs. R215's diagnoses included hypertension, renal failure, fracture, anxiety disorder and depression. MDS also indicated R215 was receiving dialysis services. R215's physician orders with print date of 5/19/25, indicated R215 had an order for Quetiapine Fumarate (antipsychotic) 50 milligram (mg) once daily for anxiety, restlessness and/or agitation and an order for Quetiapine Fumarate 12.5 mg every six hours as needed for first line for anxiety, restlessness and/or agitation. In review of R215's electronic medical record, no baseline AIMS (abnormal involuntary movement scale) assessment was completed on admission (5/14/25). R215's care plan indicated R215 had the potential for antipsychotic drug adverse reactions related to daily use of antipsychotic medication. During interview on 5/27/25 at 4:30 p.m., registered nurse manager (RN)-A stated nurse managers are responsible for completing the	21535			

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21535	Continued From page 36 AIMS assessments and they should be completed on admission and every six months if a resident is receiving an antipsychotic medication. RN-A verified R215's baseline AIMS assessment was not completed. RN-A stated it was important for the assessments to be completed to ensure resident was not having any side effects of the antipsychotic medications. The facility Psychotropic Medications policy, dated 5/12/25, identified facility would evaluate behavior interventions and alternatives before using psychotropic medications. The facility would eliminate unnecessary psychotropic medications. Psychotropic drugs include any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: anti-psychotics; anti-depressants; anti-anxiety; and hypnotics. If the physician prescribed an antipsychotic for the resident, a registered nurse must complete the Antipsychotic Medication Assessment and the Abnormal Involuntary Movement Scale in Point Click Care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications for adequate indications for use to treat a specific condition(s) as diagnosed and documented in the clinical record to ensure each resident's entire drug medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being and be consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published	21535			

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21535	Continued From page 37 in medical and/or pharmacy journals. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring medication ordered is appropriate for each resident's use. Audits should be developed to monitor medications for adequate indications for use and appropriate timeframe's for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21535			
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to develop a family council group. This had to potential to affect all family members / significant others / guardians for all 69 residents	21942	Corrected	7/4/25	

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21942	Continued From page 38 currently residing in the facility. Findings include - During interview on 5/19/25 at 2:20 p.m., the facility administrator (ADM) stated they were unable to find any documentation for the facility's Family Council. ADM stated the facility has had a change over of Activity Directors and Social Workers, and they could not locate any information. ADM stated the Resident Handbook, which was included in the Residents Admission packet, addressing the creation of a Family Council. In review of the Resident Handbook (undated), on page 10, the following was documented: "Your family has the right to meet at the center with families or other residents. The center will provide a private place and respond to any written requests that may result from family meetings. When a family group exists, the center will listen to the views and act upon grievances and recommendations of residents and family." No further information was provided by the facility SUGGESTED METHOD OF CORRECTION: The administrator and/or designee should delegate an individual to be responsible for the annual attempt to establish a family council. The administrator and/or designee should audit the delegate's efforts at forming a family council, and record when a meeting (if established) or attempts at establishing the family council occurred within each calendar year. Audits on the success or inability to form resident council should be taken to the QAPI committee for oversight to ensure compliance is achieved.	21942			

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21942	Continued From page 39 TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21942			