



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 11, 2025

Administrator
Flagstone
12500 Castlemoor Drive
Eden Prairie, MN 55344

RE: CCN: 245312
Cycle Start Date: January 29, 2025

Dear Administrator:

On January 29, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

LeAnn Huseh, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseh@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 29, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 29, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

Flagstone

February 11, 2025

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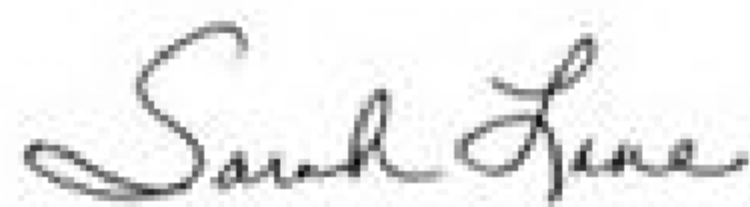
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process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

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

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

Feel free to contact me if you have questions.

Sincerely,



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



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February 11, 2025

Administrator
Flagstone
12500 Castlemoor Drive
Eden Prairie, MN 55344

Re: State Nursing Home Licensing Orders
Event ID: M4TH11

Dear Administrator:

The above facility was surveyed on January 27, 2025 through January 29, 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.

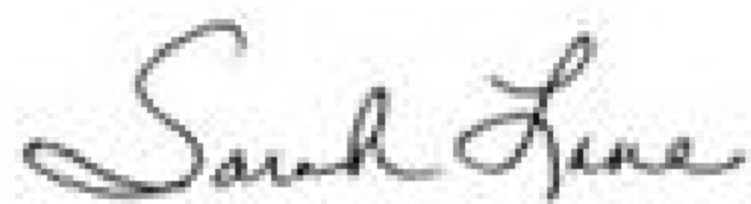
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

LeAnn Huseh, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseh@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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

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

PRINTED: 03/04/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2025
NAME OF PROVIDER OR SUPPLIER FLAGSTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 12500 CASTLEMOOR DRIVE EDEN PRAIRIE, MN 55344		
(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 1/27/25 to 1/29/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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 1/27/25 to 1/29/25, 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.				
	In addition to the recertification survey, the following complaints were reviewed.				
	The following complaints were reviewed with no deficiency issued.				
	H53122924C (MN00107485). H53122928C (MN00108148). H53125700C (MN00110023). H53126261C (MN00110252). H53126262C (MN00110235). H53126250C (MN00110278).				
	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/20/2025

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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F 000	Continued From page 1 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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the resident's ability to self-administration of medications (SAM) was assessed prior to leaving medications with the resident for 3 of 3 residents (R33, R267, R9) reviewed who had medications in their rooms. R33 R33's admission Minimum Data Set (MDS) dated 1/1/25, identified R33 had no cognitive impairment and diagnoses which included: muscle weakness, depression, and diabetes. R33 required moderate assistance with personal hygiene such as combing hair and shaving. R33's care plan dated 12/26/24, revealed R33 had an activity of daily living (ADL) self-care performance deficits due to encephalopathy, aspiration, urinary tract infection (UTI) dysphasia, and cognitive impairment. R33 wanted to be			F 554	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report. On 1/27/25, the Clinical Coordinator (CC) removed nystatin powder from R33's bedside and locked it up in the medication cart. On 1/28/25, the CC removed eye drops, tums, and hydrocortisone from R267's room for pick up by his daughter. Daughter re-educated that these medications cannot be kept in the resident's room. On 1/27/25, the CC completed a Self-Administration of Medication assessment for R9 that indicates R9 is		3/4/25

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F 554	Continued From page 2 clean and well-dressed. R33 required one assist for dressing, grooming, and hygiene. The care plan lacked information regarding self-administration of medication or medications that were kept in the resident's room. During an observation on 1/27/25 at 12:41 p.m., Nystatin powder (medication used to treat fungal skin infections) was located on the table next to the bed. R33 indicated his Nystatin powder is always there. Review of orders dated 1/21/25 revealed an order for Nystatin 1000 units/gram powder applied topically daily and twice a day as needed. No order to leave medication at bedside. Review of assessments revealed a lack of an assessment to self-administer medication. During an interview on 1/27/25 at 6:21 p.m., registered nurse (RN)-A, verified Nystatin power was on the side table next to the bed. RN-A indicated it must have been left out by mistake and removed the Nystatin powder. RN-A locked up the Nystatin powder in the medication cart. During an interview on 1/28/25 at 8:41 a.m., RN-B indicated Nystatin powder should not be have been left on the nightstand as it was a medication. RN-B verified R33 did not have an order for medications to be left at the bedside. R267 R267 quarterly MDS dated 11/23/24, identified R267 had no cognitive impairment and diagnoses of malnutrition, hypertension, and vascular disease. R267 required maximal	F 554	safe to self-administer aspercream with lidocaine. On 2/14/2025, Clinical Coordinators and Household Coordinators completed a house wide audit to ensure no other medications are in resident rooms. All findings identified have been addressed. To ensure ongoing compliance, staff are to be re-educated on the policy for Self-Administration of Medications. Education will be completed by 3/4/25. The facility plans to monitor its performance by completing random audits on medication storage for 10% of residents monthly for 3 months. Audits will be reviewed at quarterly Quality Assurance (QA) meetings until 100% compliance has been determined by the QA team. The Director of Nursing/designee will be responsible for monitoring audits for compliance.		

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F 554	Continued From page 3 assistance with personal hygiene including combing hair and shaving. R267's care plan revised on 11/22/24, revealed R267 chose not to self-administer medications. Care plan directed staff to administer medications per orders. During an observation on 1/28/25 at 12:19 p.m., R267 had refresh eye drops (for dry eyes) present on the side table. On the nightstand, R267 had one bottle of Tums (treatment for heartburn) 1000 mg, one bottle of antacids (used to neutralize acid in the stomach), one roller-ball anti-itch hydrocortisone (decrease inflammation/ itchy skin), and one hydrocortisone 1% cream (a cream to treat skin conditions such as itchy or inflamed skin). Review of signed orders dated 1/24/25, revealed R267 did not have orders for medications to be left at bedside. R267 did not have an order for Tums or refresh eye drops. R267 did have an order for hydrocortisone cream however, no order for the medication to be left at the bedside. Review of the electronic medication administration record (EMAR) for January 2025, revealed hydrocortisone cream 2.5% apply to perineal area topical two times per day, order start date of 1/20/24. No self-administration order or order to be left in the room was noted. No order for Tums, antacids, or refresh eye drops on the EMAR. Further review of EMAR for January 2025, revealed, artificial tears ophthalmic solution 0.1-0.3 %, install 1 drop in both eyes as needed for dry eyes, four times a day. Medication was			F 554			

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F 554	Continued From page 4 discontinued on 1/20/25. Review of assessments revealed R267 did not have an assessment to self-administer medications. During an interview on 1/28/25 at 2:42 p.m. licensed practical nurse (LPN)-B confirmed R267 had no orders for medications to be left at the bedside. LPN-B confirmed eye drops were on the side table, one bottle of Tums 100 mg, one bottle of antacids, one roller-ball anti-itch hydrocortisone, and one hydrocortisone 1% cream on the nightstand. Progress note from 1/28/25 at 8:09 p.m., revealed: resident was found to have one bottle of Tums, one bottle of antacids, one roller-ball anti-itch, hydrocortisone tube and refresh eye drops in the room. Writer explained why we could not let him keep the medication in there, and that they would be given to his daughter to take home. Writer then called the daughter to explain the situation and let her know that nurse practitioner would be informed and see if at all possible to have these medications ordered as needed so facility staff could administer them. R9 R9's MDS dated 1/2/25, identified R9 had no cognitive impairment and needed moderate assistance with activities of daily living. R9 had diagnoses which included hypertension, arthritis, and pain in right leg. During an observation on 1/27/25 at 12:13 p.m., Aspercream with lidocaine (medication used for pain relief) was noted on the bedside table.	F 554			

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F 554	Continued From page 5 During an observation on 1/28/25 at 8:54 a.m., Aspercream with lidocaine continued to be next to the bed on the bedside table. During an observation on 1/28/25 at 12:28 p.m., aspercream with lidocaine continued to be next to the bed on the bedside table. R9 care plan revised on 10/7/24, revealed R9 chose not to self-administer medications, except for aspercream. Review of R9's assessments revealed R9 did not have an assessment to self-administrator medications. Review of signed orders dated 11/12/24, revealed aspercream lidocaine external cream 4% (for pain relief) apply to affected area(s) topically as needed for pain apply 2 grams twice a day to painful area and apply to lower legs topical in the morning for pain apply two grams to each lower leg before compression stockings. No orders for self-administration of medications was noted. Review of EMAR for January 2025, revealed staff signed off the administration of Aspercream Lidocaine external cream 4% apply to lower legs topically in the morning for pain apply two grams to each lower leg before compression stockings, order start date was 12/12/23. EMAR lacked orders to leave medication at bedside. During an interview on 1/27/25 at 12:13 p.m., R9 stated she kept the aspercream with lidocaine at the bedside otherwise R9 would forget to apply it. R9 indicated the cream had always been on the bedside table.			F 554			

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F 554	Continued From page 6 During an interview on 1/27/25 at 6:19 p.m.,, RN-A reported the nurse would complete the self-administration order for a resident to self-administrate a medication in their room. RN-A revealed staff put on the aspercream for R9. RN-A verified R9 did not have an order to self-administer the medications. RN-A verified R9 did not have a self-administration assessment completed. RN-A verified that R9 had aspercream with lidocaine was left on her bedside table. During a follow-up interview on 1/28/25 at 4:41 p.m. director of nursing (DON) indicated if a resident was assessed to be able to self-administer medications, it would have been identified in the care plan, otherwise medications were kept in the medication cart. DON verified R33, R267 and R9 did not have self-administration assessments completed. A policy titled Medication Administration Policy dated May 2021 revealed Procedure: 17. Medication would not be left at beside unless resident had an order for self-administration of medications and had been assessed to be safe to do so and the care plan reflected the resident's ability.	F 554			
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of	F 565			3/4/25

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245312		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2025	
NAME OF PROVIDER OR SUPPLIER FLAGSTONE				STREET ADDRESS, CITY, STATE, ZIP CODE 12500 CASTLEMOOR DRIVE EDEN PRAIRIE, MN 55344			
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F 565	Continued From page 7 upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were provided a private meeting place without staff present for resident council meetings. This deficient practice had the potential to affect all five residents (R29, R39, R45, R35, and R12) who regularly attended the monthly resident council meetings. Findings include:			F 565	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report. On 2/12/2025, the Resident Council Policy		

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F 565	Continued From page 8 R29's quarterly Minimal Set Data (MDS) dated 11/27/24, revealed R29 had mild impaired cognition. R39's annual MDS dated 11/28/24 ,revealed R29 had no cognitive impairment. R45's annual MDS dated 11/20/24, revealed R45 had no cognitive impairment. R35's quarterly MDS dated 1/8/25, revealed R25 had mild cognitive impairment. R12's significant change MDS dated 12/20/24 ,revealed R12 had no cognitive impairment. During an interview on 1/28/25 at 10:01 a.m., with resident council members R29, R39, R45, R35, and R12 revealed none of the residents had been to a resident council meeting. R29, R39, R45, R35, and R12 indicated they had not been invited to attend a resident council meeting. The residents denied staff offering to bring them to a resident council meeting. The review of the resident council meeting minutes on 1/27/25 at 6:39 p.m., revealed a list of residents (R45, R39, R29, R12, and R35) who attend resident council meetings regularly. The resident council meeting minutes revealed the resident council reviewed nursing services, culinary, activities, housekeeping, and maintenance during each resident council meeting and reviewed old concerns. The review of the resident activity calendar for Thursday, 1/21/25, revealed 12:00 p.m., resident council on the first floor, and 12:30 p.m., resident			F 565	was reviewed by the Administrator, Life Enrichment Director, and Household Coordinator. On 2/13/2025, resident council invitations were distributed to all residents for the next meeting date of 2/17/25 at 10:30am. The resident council meeting minutes template has been altered to specifically include documentation that the council was asked if they desire staff to be present at the meeting. The location for the Resident Council meetings has been changed to the Chapel to provide privacy. On 2/17/25, Resident Council meeting took place in the chapel and 13 residents attended. Residents agreed that staff members, Care Center Administrator and 2 Household Coordinators could attend and help facilitate the meeting. At each meeting the residents will be offered to hold the meeting without staff present. Systemic changes were made to ensure ongoing compliancy. The standing date, time, and place has been altered for the monthly meetings per resident feedback to allow for a private setting. The Resident Council meetings will continue to be advertised on the monthly activity calendar. Life Enrichment Staff will also deliver a separate Resident Council meeting invitation each month as well. All residents needing support to get to the meeting will be escorted on the day of the meeting.		

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F 565	Continued From page 9 council on the second floor. The resident activity calendar laced identification where the meetings were located. The review of the activity calendar for Friday, 12/27/24 revealed 12:00 p.m., resident council first floor, and 12:30 p.m., resident council on the second floor. The resident activity calendar lacked documentation on where the resident council meeting was located. During review of the activity calendar for Friday, 1/24/25, revealed resident council at 12:00 p.m., for the first floor. Resident council 12:30 p.m., for the second floor. The activity calendar did not identify the location of the resident council meetings. During an interview on 1/28/25 at 10:51 a.m., activity director (AD) revealed the resident council was once a month during lunch. AD indicated her process was to go to the first-floor dining room and have resident council while residents were in the dining room eating lunch. AD then went to the second floor and had a resident council meeting while the residents were eating lunch. AD was unable to answer how people were invited. AD was unable to answer how residents who ate in their rooms or were fed by a feeding tube, attended resident council meetings. During an interview on 1/28/25 at 3:09 p.m., R12 stated she did not know that the dining room meetings were resident council meetings. R12 stated she did not bring up concerns during those meetings however, did listen to the information. R12 felt a private meeting would have been helpful to share things that should have been discussed in a more private setting.	F 565	The facility plans to monitor the resident council performance by completing monthly audits on 10% of residents. Resident Council Meeting minutes and audits will be reviewed at quarterly Quality Assurance (QA) meetings until 100% compliance has been determined by the QA team. The Life Enrichment Director and Administrator/designee will be responsible for monitoring compliance.		

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F 565	Continued From page 10 During an interview on 1/29/25 at 8:33 a.m., R45 stated she did not know that the resident council meetings were held in the dining room. R45 indicated during meals, staff would bring up topics while residents were eating. R45 indicated no one informed her that talking in the dining room was a resident council meeting. R45 would have rather had a private meeting to bring up topics she had concerns with. During an interview on 1/28/25 at 4:14 p.m., the administrator indicated resident council was on the resident activity calendar and that all residents received a resident calendar. The calendar was also hung in the hallway. The administrator was unable to verify how everyone was invited to participate if the resident did not come to the dining room for lunch. The administrator felt a resident could talk to the AD in private if there was a concern or fill out a grievance form. The administrator did not feel there was a concern with the meetings not being private and was held with dietary and nursing staff in the dining room. The administrator felt residents could have asked a staff member to discuss their concerns one-on-one if needed. A facility policy titled Resident Council Policy dated 8/24, indicated it was the policy of Presbyterian Homes and Services to provide an opportunity for residents to meet in a private space and for the facility to take reasonable attempts with the approval of the group to make residents aware of upcoming meetings in a timely matter. Procedure: 1. Staff, visitors or other guests may only attend resident group meetings only at the respective group's invitation.			F 565			

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F 657 F 657 SS=D	Continued From page 11 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. (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 follow the comprehensive care plan for 1 of 1 residents (R62) whose care plan was reviewed. Findings include:	F 657 F 657			3/4/25
			This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report.		

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F 657	Continued From page 12 R62's significant change Minimum Data Set (MDS)dated 12/24/24, identified R62 had no cognitive impairment and had diagnoses which included depression and malnutrition. R62 required extensive assistance with activities of daily living (ADL's) which include bed mobility, transfers, and toileting. R62's clinical nutrition assessment dated 12/18/24, identified R62 was on a regular diet and was independent with eating after set up. R62's care plan revised 12/30/24, identified R62 had limited physical mobility and self-care deficits related to failure to thrive, protein malnutrition and weigh loss. R62's intervention included: R62 needed to get up in her wheelchair for all meals. R62's care sheet dated 1/17/25, identified R62 was to be up in wheelchair for all meals. During an observation on 1/28/25 at 12:20 p.m., nursing assistance (NA)-F entered R62's room with R62's meal tray. NA-F set R62's meal tray on the bedside table and asked R62 if she wanted to be boosted up in bed prior to eating. NA-F boosted R62 up in bed, elevated the head of the bed and pushed R62's bedside table over R62's bed. NA-F asked R62 if she wanted the head of bed up higher so R62 could eat better. R62 indicated she did and NA-F raised the head of her bed. NA-F told R62 what was on her tray and left R62's room. During an interview on 1/28/25 at 12:28 p.m., NA-F stated staff were to expected to get R62 up into her wheelchair for all meals. NA-F further stated she did not ask R62 to get up into her wheelchair because, "R62 would probably refuse	F 657	On 2/13/2025, R62's care plan was updated to reflect R62 preference on staying in bed for meals. On 2/13/25, Clinical Administrator and Administrator reviewed the Care Plan Policy. On 2/19/2025 a house wide audit was completed by the Clinical Coordinators to ensure resident mealtime preferences are correct and aligned with their care plan. No other residents found to be an issue. Education to be completed by 3/4/25 for all staff on Care Plan Policy with an emphasis on following plan of care and importance of communicating changes to resident preferences to Clinical Coordinator to ensure updates can be made to plan of care. The facility plans to monitor its performance by completing random care observation audits for 10% of residents monthly for 3 months. Audits will be reviewed at quarterly Quality Assurance (QA) meetings until 100% compliance has been determined by the QA team. The Director of Nursing/designee will be responsible for monitoring audits for compliance.		

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F 657	Continued From page 13 anyway." NA-F reviewed the care sheet for R62 and indicated the care sheet stated R62 was to be up in her wheelchair for all meals. During an interview on 1/28/25 at 3:10 p.m., registered nurse (RN)-C confirmed R62 was to be up in her wheelchair for all meals. RN-C stated staff were to report if R62 refused to get up in her wheelchair. During an interview on 1/28/25 at 4:39 p.m., household coordinator (HC) confirmed that R62 was to be up in her wheelchair for all meals for repositioning and quality of life. HC indicated R62's careplan and caresheet stated R62 was to be up for all meals. During an interview on 1/29/25 at 10:33 a.m., director of nursing (DON) confirmed the above findings and stated it was her expectation that staff would follow residents care plans. DON stated she would expect staff to report any refusals to the RN and document the refusal. Requested a careplan policy, however, one was not provided.	F 657			
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with personal hygiene for 4 of 4 residents (R7,	F 677	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission	3/4/25	

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F 677	Continued From page 14 R33, R267) reviewed for activities of daily living (ADL)'s. Findings include: R7 R7's quarterly Minimum Data Set (MDS) dated 11/19/24, identified R7 had severe cognitive impairment and had diagnoses which included renal insufficiency, dementia, and depression. Identified R7 required one person physical assist from staff with personal hygiene. R7's current care plan revised 2/27/24, indicated R7 had deficits with ADL's related to dementia and muscle weakness. Indicated R7 required staff assistance with personal hygiene and preferred to have staff assistance with removing facial hair. R7's annual comprehensive Care Area Assessment (CAA) dated 6/6/24, identified R7 required assistance with ADL's. Identified R7 had an activity intolerance related to weakness, physical limitations and dementia. R7's care sheet undated, identified it was a standard for staff to shave residents daily. During an observation on 1/27/25 at 1:18 p.m., R7 was sitting in her wheelchair in the day room and had several half inch long white facial hairs on her chin and above her upper lip. During an interview on 1/27/25 at 1:26 p.m., family member (FM)-A stated R7 preferred to be shaved when facial hair was visible.			F 677	of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report. On 1/28/25, R7's facial hair was shaved. On 1/28/2025, R33's shaver was replaced with a functioning one. On 1/28/25, staff attempted to shave the facial hair for R33, but he refused. The Household Coordinator interviewed R33 to determine his preferences for frequency for shaving. The Resident Assistant Assignment sheet and care plan have been updated to reflect current preferences. On 1/29/25, LPN-B shaved R267. The Household Coordinator interviewed R267 to determine his preferences for frequency for shaving. The Resident Assistant Assignment sheet and care plan have been updated to reflect current preferences. On 2/19/2025, Household Coordinators completed a house wide audit to ensure resident preferences regarding shaving are being followed. All findings have been identified and corrected. On 2/13/2025, the Resident Care Policy was reviewed by the Administrator and Clinical Administrator. Education to be completed by 3/4/25 for all staff on Resident Care Policy and ADLs. The facility plans to monitor its performance by completing random facial hair audits for 10% of residents monthly for 3 months. Audits will be reviewed at quarterly Quality Assurance (QA) meetings until 100%		

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F 677	Continued From page 15 During an observation on 1/28/25 at 8:11 a.m., R7 was sitting in her wheelchair at the dining room table. R7 continued to have several half inch long white facial hairs on her chin and above her upper lip. During a joint interview on 1/28/25 at 8:51 a.m., nursing assistant (NA)-A and licensed practical nurse (LPN)-A verified R7 had several long white facial hairs. NA-A stated R7 required staff assistance to shave facial hair. NA-A stated she had not assisted R7 with shaving recently and was unsure the last time R7 had been shaved. LPN-A stated her expectation was that R7 would have been shaved as soon as facial hair was present. R33 R33's MDS dated 1/1/25, identified R33 had no cognitive impairment and diagnoses which included muscle weakness, depression, and diabetes. R33 required moderate assistance with personal hygiene such as combing hair and shaving. R33's care plan dated 12/26/24, revealed R33 had an activities of daily living (ADL) self-care performance deficits due to encephalopathy, aspiration, urinary tract infection (UTI) dysphasia, and cognitive impairment. R33 wanted to be clean and well dressed. R33 required one assist for dressing, grooming, and hygiene. Care sheet titled pioneer park west dated 1/28/25, revealed standards of care: call light in reach, encourage use. Shave residents daily. During an interview on 1/27/25 at 12:30 p.m., R33			F 677	compliance has been determined by the QA team. The Director of Nursing/designee will be responsible for monitoring audits for compliance.		

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F 677	Continued From page 16 had approximately 2 cubic centimeters (cm) of facial hair on his chin, upper lip, and cheeks. During an observation on 1/28/25 at 8:47 a.m., R33 had 2 cm of facial hair on his chin, upper lip, and cheeks. . During an observation at 1/28/25 p.m. at 3:28 p.m., R33 had 2 cm of facial hair on his chin, upper lip, and cheeks. During an interview on 1/27/25 at 12:30 p.m., R33 reported his shaver did not work and was under the impression the facility requested residents buy their own shavers and did not want to spend money on a shaver. R33 had approximately 2 cubic centimeters (cm) of facial hair. During an interview on 1/28/25 at 3:28 p.m., nursing assistant (NA)-A verified R33 had long facial hair around 2 or 3 cm and needed to be shaved. NA-B verified that the care sheet stated to shave residents daily. NA-A stated shaving tasks did not get completed daily. NA-B indicated residents did not get shaved often. NA-B indicated that the facility had shavers for residents to sue however would have to ask a supervisor to obtain one since they were not kept in the storage room. During an interview on 1/28/25 at 2:28 p.m., registered nurse (RN)-B indicated a resident should have been shaved on their shower day or shaved more often depending on the resident preference. R267 R267 quarterly MDS dated 11/23/24, identified	F 677			

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F 677	Continued From page 17 R267 had no cognitive impairment and had diagnoses of malnutrition, hypertension, and vascular disease. R267 required maximal assistance with personally hygiene, including combing hair and shaving. R267 care plan revised on 11/22/24, revealed R267 had an ADL self-care performance deficit related to weakness, impaired mobility, self-care ability, severe malnutrition, dysphasia, and pain in legs. R267 wanted to be clean and well dressed. R267 needed assist of one for dressing, grooming, and hygiene. Care sheet titled pioneer park west dated 1/27/25, revealed Standards of care: call light in reach, encourage use. Shave residents daily. During an observation on 1/27/25 at 1:18 p.m., R267 had approximately 2 cubic centimeters (cm) of hair growth on his chin, upper lip, and cheeks. During an observation on 1/28/25 at 8:07 a.m., R267 had a razor sitting on his bedside table with 2-3 cm of hair growth on his on his chin, upper lip, and cheeks. During an observation on 1/29/25 at 7:58 a.m., R267 was laying in bed dressed ready to get up, R267 had approximately 3 cm of facial hair. Licensed practical nurse (LPN)-B and nursing assistant (NA)-C entered the room and proceeded to assist R267 with ADLs. LPN-B then shaved R267. During an interview on 1/27/25 at 1:18 p.m., R267 indicated he was supposed to be shaved on Mondays once a week when he has his bath. R267 stated he liked to be shaved often.	F 677			

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F 677	Continued From page 18 During an interview on 1/29/25 at 12:19 p.m., R267's daughter indicated R267 liked to be shaved often and did not want facial hair. R267 daughter had bought R267 two different razors. During an interview on 1/28/25 at 1:42 p.m., NA-D did not know how often R267 should have been shaved. NA-D verified that R267 had long facial hair around 3 cm and should have been shaved. R267 stated to NA-D, "I like my face shaved, I don't like a mustache." NA-D took out care sheet and verified R267 received a bath on Monday and that R267 would have to request to be shaved. During an interview on 1/28/25 at 2:52 p.m., director of nursing (DON) indicated R7 required staff assistance with shaving. DON stated her expectation was R7 would have been shaved when facial hair was present. During a follow-up interview on 1/28/25 at 4:38 p.m., DON stated the expectation was for staff to shave residents as needed. Staff were expected to do a body audit once a week with the shower and shave at that time if needed. The facility could have provided a razor if the resident did not have their own. A Facility policy titled Activities of Daily Living (ADL's) dated 3/15/21, indicated the facility would have provided care and services for hygiene per the resident's individualized plan of care. Further indicated ADL care would have been provided based on resident preferences.	F 677			
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)	F 679			3/4/25

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F 679	Continued From page 19 §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meaningful and engaging activities for 1 of 1 residents (R62) reviewed for activities. Findings include: R62's significant change Minimum Data Set (MDS) dated 12/24/24, identified R62 had no cognitive impairment and had diagnoses which included depression, failure to thrive and was currently receiving hospice services. R62 required extensive assistance with activities of daily living (ADL's) which include bed mobility, transfers, and toileting. R62's LTC therapeutic recreation and activities assessment dated 12/24/24, indicated R62 preferred day/activity room and independent activities in her room. R62's preferences were visits from her daughter, talking with staff, watching television, one to one visits, and activities in a group setting. R62's care plan revised 12/30/24, identified R62			F 679	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report. Life Enrichment (LE) Director provided R62 with the January activity calendar on 1/28/25 upon learning from the surveyor that R62 reported not receiving one. Monthly activity calendars will continue to be hand delivered to resident rooms on the 1st of the month by LE staff. Additional copies are available upon request. Additional copies are on hand at the reception desk all month long. The activity calendar is also published on the Flagstone website and posted on the wall in the facility. On 2/19/2025 a comprehensive Therapeutic Recreation Assessment was completed for R62 to reassess for activities of interest and on 2/13/2025 a Brief Interview of Mental		

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F 679	Continued From page 20 had a long term goal to choose her own activities. R62's careplan further indicated R62 was to be invited to scheduled activities, provided an activities calendar, and provided supplies to pursue her activity interests. During an observation and interview on 1/27/25 at 5:03 p.m., R62 stated she had not been offered any visitors throughout the day and was feeling very sad. R62 further sated she had not been offered any activities since she was admitted. R62 indicated she did not remember seeing an activities calendar in her room. A scan of the room was completed and no activities calendar was noted. During an observation and interview on 1/28/25 at 12:11 p.m., R62 was laying in her bed using her personal cellular telephone. R62 continued to state she did not have an activities calendar in her room and had never received one for the month of January 25. R62 stated she had no way of knowing what activities were going on in the facility. R62 verbalized that she not had any visitors today. R62 stated "this is what I do all day, just lay here in this bed". R62 further stated she wished she had an activities calendar, was invited to actives throughout the day, and had visits from the staff. During an interview on 1/28/25 at 12:28 p.m., nursing assistant (NA)-F stated the life enrichment team was in charge of handing out activity calendars to each resident. NA-F further stated the life enrichment team had daily activities in the community room and R62 enjoyed attending them at times. During an interview on 1/28/25 at 2:38 p.m., life			F 679	Status (BIMs) was completed to reassess cognition. On 2/19/2025, R62's care plan was updated to reflect preferences. A house wide audit was completed on 2/19/2025 by the Life Enrichment Director to ensure that residents are being offered 1:1's in regards to resident preferences. All findings corrected. Beginning 2/17/25, LE Director will ensure all LE staff take attendance for all programs and 1:1 visits carried out by LE team. Systemic changes include ensuring that attendance tracking and documentation occurs for all programs and 1:1 visits. The facility plans to monitor ongoing compliance by completing monthly audits on activity/1:1 charting for 10% of residents. The facility will also monitor compliance by soliciting feedback from the Resident Council monthly on activities and confirm receipt of calendars. This information along with the audits will be brought to the QA committee quarterly until compliance has been determined by the QA team. The Life Enrichment Director and Administrator/designee will be responsible for monitoring compliance.		

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F 679	Continued From page 21 enrichment director (LED) confirmed calendars were handed out to each resident on the first of every month. LED stated life enrichment staff were expected to go to R62's room and invite her to group activities. LED further stated she was not aware R62 did not have an activities calendar in her room and that R62 had not been invited to any group activities. LED indicated staff do not document when a resident completed an activity so she had no way of knowing what activities R62 had been invited to. LED confirmed R62's activity interests. During an interview on 1/29/25 at 10:33 a.m., director of nursing confirmed the above findings and stated no documentation was completed to indicate residents received activities throughout the day. DON stated her expectation was staff were to invite and engage all resident in daily activities.	F 679			
F 689 SS=D	Requested facility for the Activities Program, however, one was not provided. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement	F 689			3/4/25
			This plan of correction constitutes this facility's written allegation of compliance		

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F 689	Continued From page 22 interventions for 1 of 1 residents (R17) who had a recent fall with a significant injury in the facility and remained at high risk for falls. Findings include: R17's significant change Minimum Data Set (MDS) dated 12/23/24, identified R17 had severe cognitive impairment and had diagnoses which included anxiety disorder, dementia, and left humerus (bone in the arm) fracture. Identified R17 required extensive assistance with activities of daily living (ADL's) which include bed mobility, transfers, and toileting. Identified R17 had one fall with a major injury since last assessment. R17's significant change Care Area Assessment (CAA) dated 12/27/24, identified R17 had one fall since prior assessment. Identified R17 had a fall while using a standing lift and fractured her left humerus Identified R17 remained at high risk for falls related to dementia, cognitive impairment with agitation and depression. Further identified R17 was now to use a full body lift for transfers. R17's Fall Risk Screening Tool dated 12/21/24, identified R17 was at high risk for falls related to a recent fall which resulted in a fracture of the left humerus. Identified R17 now required a full body lift with assist of two. R17's care plan revised 12/27/24, identified R17 had a history of falls with fractures and was at risk for further falls related to mobility/balance problems. R17's interventions included: Reassess for standing lift when appropriate, keep bed in lowest position, and place wheelchair next to bed when in bed. Identified R17 wore a sling to left arm and required assistance with dressing,			F 689	for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report. R17 signed onto hospice on 1/27/25 and the interdisciplinary team was in process of completing significant change assessments for R17. On 1/30/25, Clinical Coordinator completed the Comprehensive Nursing Data assessment for R17 to reassess for Fall Risk. R17's care planned fall interventions were updated to reflect her current condition. On 2/17/2025, an audit was completed for all residents at risk for falls to ensure that interventions remain current and appropriate. All findings remain current and appropriate. On 2/13/2025, the Fall Prevention and Management Program Policy was reviewed by the Administrator and Clinical Administrator. Education to be completed by 3/4/25 for all staff following fall interventions on reporting when an intervention is no longer relevant due to a change in condition. The facility plans to monitor its performance by completing random care observation audits for 10% of residents monthly for 3 months. Audits will be reviewed at quarterly Quality Assurance (QA) meetings until 100% compliance has been determined by the QA team. The Director of Nursing/designee will be responsible for monitoring audits for compliance.		

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F 689	Continued From page 23 toileting and transfers. R17's care sheet undated, identified staff were to place R17's wheelchair next to bed. Review of R17's progress notes from 12/14/24 to 12/15/24, identified the following: -12/14/24 at 2:40 p.m., NA was transferring R17 in a standing lift when R17 let go of the bar and NA lowered 17 to the floor, called for assistance and used a full body lift to place R17 into bed. -12/15/24 at 10:14 a.m., R17 complained of increased pain in left shoulder, Xray and sling to left shoulder were ordered. -12/15/24 at 12:58 p.m., Fracture to left Humeral head and neck. During an observation on 1/28/25 at 3:03 p.m., R17 was lying in bed and wheelchair was five feet from R17's bed facing the opposite direction. During an observation on 1/29/25 at 7:11 a.m., R17 was lying in bed and wheelchair was in the bathroom approximately 10 feet from R17's bed. During an interview on 1/29/25 at 7:15 a.m., nursing assistant (NA)-A stated R17 had a recent fall and broke her left arm. NA-A stated R17's wheelchair was to be placed next to R17's bed as a fall intervention. During an interview on 1/29/25 at 7:20 a.m., nurse manager (NM)-A verified R 17's bed was lying in bed and the wheelchair was in the bathroom which was approximately 10 feet from R17's bed. NM-A stated R17 was at risk for falls	F 689			

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F 689	Continued From page 24 and had a recent fall with a fracture. NM-A further stated her expectation was that the wheelchair would have been placed next to R17's bed. During an interview on 1/29/25 at 8:03 a.m., director of nursing (DON) verified R17 had a recent fall with a fracture. DON verified R17's wheelchair was to be placed next to the bed when R17 was in bed. DON stated her expectation was that the care plan would have been followed to help prevent future falls. Review of a facility policy titled Fall Prevention and Management Program Policy revised 4/21, identified all residents were to be assessed for fall risk and nursing staff would implement interventions according to resident specific risk factors. Further identified care plans would indicate the resident specific interventions to prevent falls	F 689			
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4)	F 712			3/4/25

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F 712	Continued From page 25 §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure newly admitted residents received 30 day physician visits for the first 90 days for 1 of 1 residents (R30) reviewed for 30 day physician visits. Findings include: R30's admission Minimum Data Set (MDS) dated 12/1/24, identified R30 had no cognitive impairment and had diagnoses which included chronic kidney disease (CKD), an indwelling catheter, and a history of urinary tract infections. R30 required moderate assistance with activities of daily living (ADL's) bathing, transfers, and toileting.	F 712	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report. On 1/29/25, the facility requested that Dr. Bartlett complete an MD visit for R30. On 2/11/25, R30 was seen by Dr. Bartlett at the facility. An audit was completed on 2/17/2025 by the Health Information Manager (HIM) to ensure all residents are up to date with provider regulations. All findings have been corrected. HIM has		

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F 712	Continued From page 26 R30's facesheet indicated R30 was admitted to the facility on 11/25/24. R30's medical record lacked evidence R30 was seen by a physician since admission. During an interview on 1/27/25 at 6:29 p.m., R30 stated he had not seen a physician since he was admitted to the facility. R30 further stated he had requested to see a physician and staff avoided him when he asked. R30 indicated he had seen a nurse practitioner however had wanted to see a physician. During an interview on 1/29/25 at 10:08 a.m., nurse manager (NM)-B stated R30 had been seen three times by a nurse practitioner (NP) since admission however, R30 had not been seen by a physician since admission. During an interview on 1/29/25 at 10:38 a.m., administrator and director of nursing (DON) confirmed the above findings. Administrator stated her expectations were residents received physicians visits every 30 days for the first 90 days after admission. Review of facility policy titled Physicians Services, modified 11/19, the frequency of physicians visits would consist of at least every 30 days for the first 90 days after admission.	F 712	created a tracking spreadsheet for MD visits to ensure each resident is seen in accordance with regulations. On 2/13/2025, the Physician Services Policy was reviewed by the Administrator and Clinical Administrator. The facility plans to monitor its performance completing weekly audits of the physician tracking spreadsheet for 4 weeks and then monthly thereafter. Audits will be reviewed at quarterly Quality Assurance (QA) meetings until 100% compliance has been determined by the QA team. The Director of Nursing/designee will be responsible for monitoring audits for compliance.		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755			3/4/25

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F 755	Continued From page 27 them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a system to ensure medications were available to administer as ordered for 2 of 2 residents (R61, R57) identified who did not receive medications as ordered. Findings Include: R61			F 755	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report. On 1/28/25, the facility approved		

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F 755	Continued From page 28 R61's admission Minimum Data Set (MDS) dated 1/5/25, identified R61 had moderate cognitive impairment and diagnoses which included: Crohn's disease (chronic condition that causes inflammation of gastrointestinal tract), heart failure and chronic kidney disease. During an observation on 1/27/25 at 4:38 p.m., trained medication aide (TMA)-A set up R61's medications. TMA-A indicated R61 was to receive Creon (medication that replaces digestive enzymes in body) however it was not available to administer, so would contact the pharmacy to order it again. R61's Discharge Orders And Information hospital form dated 12/30/24, included the following: -Creon 24000-76000 units oral capsule, take one capsule by mouth three times daily. R61's January Electronic Medication Administration Record (EMAR) identified the following: -Creon Oral Capsule Delayed Release Particles 24000-76000 Unit. Give 1 capsule by mouth with meals for pancreatic insufficiency, from January 22 at 1200 p.m. to January 28 at 8:00 a.m., it was not administered 18 times. Review of R61's progress notes from 1/22/25, to 1/27/25, identified the following: -1/24/25 at 5:05 p.m., Creon Oral Capsule, no supply, called pharmacy and informed nurse. -1/27/25 at 4:46 p.m., Creon Oral Capsule, need to be reordered. R61's progress notes lacked documentation R61's provider had been notified R61's Creon			F 755	Pharmacy to bill the facility for the cost of the Creon and the Pharmacy delivered the medication on 1/28/25. R61 received the Creon as prescribed upon the arrival of the medication. Clinical Administrator completed a Medication Variance Form. R57 did not receive Zoloft as ordered on 1/26 and 1/27. On 1/28/25, the supply was found and R57 received the medication. Clinical Administrator completed a Medication Variance Form. Any errors identified have been addressed. On 2/13/25, Clinical Administrator and Clinical Coordinators reviewed Medication Administration Policy. Education to be completed by 3/4/25 for licensed staff and Trained Medication Administrators regarding missed medication and notification of nurse and the provider. In order to ensure deficient practice will not reoccur, Clinical Coordinators will complete Admin Medication Audit Review each business day and follow up on any missed medication. Trends will be reviewed at quarterly Quality Assurance (QA) meetings until 100% compliance has been determined by the QA team. The Director of Nursing/designee will be responsible for monitoring audits for compliance.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2025
NAME OF PROVIDER OR SUPPLIER FLAGSTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 12500 CASTLEMOOR DRIVE EDEN PRAIRIE, MN 55344		
(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
F 755	Continued From page 29 medication was not available. During an interview on 1/28/25 at 10:16 a.m., clinical coordinator registered nurse (RN)-B confirmed R61's Creon was not available, and had not been administered since 1/22/25. RN-B stated she became aware that morning that R61 was out of Creon medication, and would make sure it was available to give later that day. RN-B indicated the facility's usual process was to reorder medication when the medication ran out from pharmacy. RN-B stated she would need to contact director of nursing (DON) to see if anything else could be done. During a telephone interview on 1/28/25 at 12:37 p.m., pharmacy consultant (PC)-A stated the expectation was if a resident was out of a medication, to contact the pharmacy, and if not available to try a different pharmacy. PC-A also expected the facility to contact the physician to see if the medication should be held until received, or if a different medication should be administered, and document. PC-A stated that if R61 did not have Creon as ordered, R61 could have gastrointestinal (GI) upset. PC-A indicated if a resident did not receive Zoloft as ordered, they may be fine, or it may affect their depression, or cause anxiety. During a telephone interview on 1/28/25, at 11:54 p.m., nurse practitioner (NP)-A confirmed she was familiar with R61's care and had not been notified R61 was not receiving Creon as ordered. NP-A stated if R61 did not have Creon medication available to administer, her expectation was that pharmacy would be notified, and if still unavailable that she or triage would be contacted because it was important residents receive their	F 755			

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F 755	Continued From page 30 medications as prescribed. During a follow up interview on 1/29/25 at 8:45 a.m., RN-B stated R61's Creon had been ordered and would be delivered that day. RN-B indicated they notified R61's provider of R61's missed Creon medication, and they spoke to PC-A who advised them to monitor for possible effects of gastrointestinal symptoms from R61 not receiving receiving the Creon as ordered, so R61 would be monitored. R57 R57's quarterly MDS dated 12/11/24, identified R57 had moderate cognitive impairment and diagnoses which included: hypertension, depression Alzheimer's, aphasia, and seizure disorder. During an observation on 1/28/25 at 9:01 a.m., TMA-E went to set up R57 medications. TMA-E went to take Zoloft (for depression) 25 Milligram (mg) out of the medication cart. TMA-E was unable to locate the medication in the medication cart. TMA-E indicated the medication could have been in the medication room and would check and if unable to locate the medication, then the pharmacy would be contacted. During an interview on 1/28/25 at 1:46 p.m., TMA-E verified that R57 did not have the Zoloft medication in the medication cart but was able to locate the medication in the medication room and was able to give the medication. TMA-E indicated			F 755			

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F 755	Continued From page 31 the process would be to reorder the medication according to the date on the medication card. If a resident missed a medication the facility would make the pharmacy aware the medication was currently out and needed to be refilled. The nurse was responsible for updating the physician on the missed medication dose. TMA-E verified the EMAR reflected R57 and did not receive Zoloft 25 mg on 1/26/25 and 1/27/25. Review of the EMAR revealed that R57 did not receive Zoloft 25 mg on 1/26/25 and 1/27/25. Review of the signed physician orders signed 1/27/25 revealed R57 had an order for Zoloft 25 mg, take one tablet by mouth daily. After review of the progress notes from 1/25/25 to 1/27/25, revealed the pharmacy and physician were not updated that R57 missed two doses of Zoloft 25 mg. During an interview on 1/28/25 at 2:52 p.m., RN-B indicated the facility process to reorder medication was to pull the sticker on the medication card when the medication was low and fax the sticker to the pharmacy. It was the responsibility of the floor nurse to let the provider know a medication dose was missed. RN-B indicated she was unaware R57 had missed two doses of Zoloft 25 mg on 1/26/25 and 1/27/25. During a joint interview on 1/28/25 at 2:56 p.m. with director of nursing (DON) and medical director (MD), DON stated facility's usual process was a medication was not available to administer, the TMA would inform the nurse, the pharmacy would be called and a refill form would be completed. DON confirmed she had been made			F 755			

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F 755	Continued From page 32 aware earlier that day that R61 had been out of Creon medication since 1/22/25. DON stated they had discovered it was an insurance reason why R61's Creon medication had not been sent, and the facility would be purchasing the medication for R61, so would be available. MD stated he would expect the resident's provider would be contacted if a medication was not available to administer, so they could determine if the resident could wait for the medication to be filled, or if it needed to be urgently refilled. MD stated R61's Creon was not a life threatening medication, they had assessed R61, who did not have diarrhea, which could have been a symptom of not receiving the Creon, so he felt R61 had not suffered consequences of not receiving the medication. DON also confirmed R57 had been out of Zolofit medication to administer, but the medication was now available. MD stated R57 did not suffer any consequences of the two missed Zolofit doses as 25 mg. was a low dose. The facility policy titled Medication Administration Policy revised 5/21, identified the policy was to ensure safe, effective and timely drug therapy, to provide for an accurate and concise documentation system. The policy included that the eight rights of drug administration would be followed when administering all medications: right resident, right drug, right dose, right dosage form, right route, right time, right reason and right documentation. The policy included instruction to fax or call the pharmacy for medications, and if medication was not available the emergency kit may be used according to policy. The policy did not identify instruction of what to do if medication was not available to administer from the emergency kit, or to notify the resident's provider if a medication was not available to administer.	F 755			

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F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility had a 7% percent medication error rate for 2 of 4 residents(R61, R44) observed during medication administration. Findings Include: R61 R61's admission Minimum Data Set (MDS) dated 1/5/25, identified R61 had moderate cognitive impairment and diagnoses which included: Crohn's disease (chronic condition that causes inflammation of gastrointestinal tract), heart failure and chronic kidney disease. R61's Discharge Orders And Information hospital form dated 12/30/24, included the following: -Creon 24000-76000 units oral capsule, take one capsule by mouth three times daily. During an observation on 1/27/25 at 4:38 p.m. trained medication aide (TMA)-A set up R61's medications. TMA-A indicated R61 was to receive Creon (medication that replaced digestive enzymes in body) however it was not available, so she would contact the pharmacy to order it again. R44	F 759	This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report. On 1/28/25, the facility approved Pharmacy to bill the facility for the cost of the Creon and the Pharmacy delivered the medication on 1/28/25. R61 received the Creon as prescribed upon the arrival of the medication. Clinical Administrator completed a Medication Variance Form. Any errors identified have been addressed. On 1/29/25, the nurse and TMA for R44 were re-educated to follow orders on lidocaine strength. On 1/29/25, the nurse on duty replaced the existing lidocaine patch with the correct lidocaine strength patch. Clinical Administrator completed a Medication Variance Form. On 2/13/25, Clinical Administrator and Clinical Coordinators reviewed Medication Administration Policy. Education to be completed by 3/4/25 for licensed staff and Trained Medication Administrators on following the 8 rights of medication	3/4/25	

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F 759	Continued From page 34 R44's admission MDS dated 11/21/24, identified R44 was cognitively intact, and had diagnoses which included: arthritis, sciatica right side (pain that travels nerve from buttocks down leg) and other low back pain. R44's Order Summary Report signed and dated 1/23/25, included the following: -Lidocaine External Patch 5% apply to back topically in the morning for pain. on for 12 hours, off for 12 hours and remove per schedule. Order date 1/16/25. During an observation on 1/29/25, at 7:21 a.m., TMA-A set up R44's medications which included: Lidocaine patch labeled: 4%, apply 1 patch every day for 12 hours and leave off for 12 hours. TMA-A indicated the order was for a Lidocaine 5% patch, but stated the nurse had called the pharmacy and they did not have 5% Lidocaine so they sent the Lidocaine 4% patches instead. At 7:39 a.m., TMA-A entered R44's room, and administered medications, which included applying the Lidocaine 4% patch to R44's lower back. During an interview on 1/28/25 at 10:16 a.m., clinical coordinator registered nurse (RN)-B confirmed R61's Creon was not available, and not administered since 1/22/25. RN-B indicated the facility's usual process was to reorder medication if out from pharmacy. RN-B stated she would need to contact director of nursing (DON) to see if anything else should be done. During a follow up interview on 1/29/25 at 8:45 a.m., RN-B stated TMA-A had informed her that R44's Lidocaine administered was not the correct dosage. RN-B confirmed that R44's Lidocaine patch order had	F 759	administration. To ensure deficient practice will not recur, Clinical Coordinators will complete Admin Medication Audit Review each business day and follow up on any missed medication. Additionally, random audits will be completed monthly for all residents with lidocaine patches. Trends will be reviewed at quarterly Quality Assurance (QA) meetings until 100% compliance has been determined by the QA team. The Director of Nursing/designee will be responsible for monitoring audits for compliance.		

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F 759	Continued From page 35 recently been updated to 5% instead of 4%. RN-B indicated the facility health unit coordinator (HUC) entered orders into the electronic health record, which was verified by a nurse, then faxed the pharmacy. RN-B stated it was important that R44 received the correct Lidocaine patch dosage, for pain relief and to administer medications as ordered. During a telephone interview on 1/28/25 at 12:37 p.m. pharmacy consultant (PC)-A stated the expectation was if a resident was out of a medication, to contact the pharmacy, and if not available to try a different pharmacy. PC-A also expected the facility to contact the physician to see if the medication should be held until received, or if a different medication should be administered, and document. C-A stated that if R61 did not have Creon as ordered, R61 could have gastrointestinal (GI) upset. During a joint interview on 1/28/25 at 2:56 p.m., with director of nursing (DON) and medical director (MD), DON stated facility's usual process if a medication was not available to administer, the TMA would inform the nurse, the pharmacy would be called and a refill form would be completed. DON confirmed she had been made aware earlier that day that R61 had been out of Creon medication since 1/22/25. DON stated they had discovered it was an insurance reason why R61's Creon medication had not been sent, and the that the facility would be purchasing the medication for R61, to be available. MD stated he would expect the resident's provider would be contacted if a medication was not available to administer, so they could determine if the resident could wait for the medication to be filled, or if it needed to be urgently refilled.	F 759			

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F 759	Continued From page 36 During a follow up interview on 1/29/25 at 10:04 a.m., DON verified R44's lidocaine 5% patch order was updated on 1/16/25, with a start date of 1/17/25. DON stated the facility's usual practice for new orders included the HUC to transcribe the orders, a nurse confirmed the order, then HUC would send order to pharmacy. DON indicated her expectation was for TMA-A to follow the facility's policy for medication checks before administering the patch. The facility policy titled Medication Administration Policy revised 5/21, identified the policy was to ensure safe, effective and timely drug therapy, to provide for an accurate and concise documentation system. Medication Administration procedure identified: the eight rights of drug administration would be followed when administering all medications: right resident, right drug, right dose, right dosage form, right route, right time, right reason and right documentation.			F 759			

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K 000	INITIAL COMMENTS An annual Life Safety Code survey was conducted on 01/30/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Flagstone was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/20/2025

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 1 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Flagstone is a 5-story building with a basement. The building was constructed in 2020 and was determined to be of Type II(222) construction. The skilled nursing home is located on the first two floors, with assisted living on floors three and four and a memory care unit on the fifth floor. The facility is fully protected throughout by an automatic fire sprinkler system. In addition, the building has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms monitored for automatic fire department notification.	K 000			

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K 000	Continued From page 2	K 000			
K 353 SS=F	The facility has a capacity of 72 beds and had a census of 65 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: 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 observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA	K 353	On 2/21/25, the quarterly fire system sprinkler inspection will be completed by Summit Fire Protection. Environmental Services Director signed a contract for Summit Fire Protection to perform these inspections quarterly on an ongoing basis. A recurring task was added to TELS Work	3/4/25	

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K 353	Continued From page 3 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility. Findings include: 1. On 01/30/2025, between 9:00am and 11:00am, it was revealed by observation that storage materials had been placed on a storage rack,bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. The obstruction was found in: lower level kitchen storage 2. On 01/30/2025 between 9:00am and 11:00am, it was revealed by a review of available documentation that at the time of the survey the facility could not provide inspection reports for quarterly fire sprinkler inspections. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 353	Order system to ensure ongoing compliance. ESD will be responsible for this correction action and monitoring of compliance. On 1/31/25, the Culinary Director and the Environmental Services Director moved all of the shelving unit racks lower to ensure 18” clearance from sprinkler heads. ESD has added in a reoccurring TELS Work Order task to audit sprinkler head clearance weekly for 4 weeks and then monthly thereafter. ESD will be responsible for this correction action and monitoring of compliance.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00973	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
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 1/27/25 to 1/29/25, 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

02/20/25

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. In addition to the recertification survey, the following complaints were reviewed. The following complaints were reviewed with no licensing orders issued. H53122924C (MN00107485). H53122928C (MN00108148). H53125700C (MN00110023). H53126261C (MN00110252). H53126262C (MN00110235). H53126250C (MN00110278). 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	2 000			

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2 000	Continued From page 2 is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement	2 830	Corrected		3/4/25

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2 830	Continued From page 3 interventions for 1 of 1 residents (R17) who had a recent fall with a significant injury in the facility and remained at high risk for falls. Findings include: R17's significant change Minimum Data Set (MDS) dated 12/23/24, identified R17 had severe cognitive impairment and had diagnoses which included anxiety disorder, dementia, and left humerus (bone in the arm) fracture. Identified R17 required extensive assistance with activities of daily living (ADL's) which include bed mobility, transfers, and toileting. Identified R17 had one fall with a major injury since last assessment. R17's significant change Care Area Assessment (CAA) dated 12/27/24, identified R17 had one fall since prior assessment. Identified R17 had a fall while using a standing lift and fractured her left humerus Identified R17 remained at high risk for falls related to dementia, cognitive impairment with agitation and depression. Further identified R17 was now to use a full body lift for transfers. R17's Fall Risk Screening Tool dated 12/21/24, identified R17 was at high risk for falls related to a recent fall which resulted in a fracture of the left humerus. Identified R17 now required a full body lift with assist of two. R17's care plan revised 12/27/24, identified R17 had a history of falls with fractures and was at risk for further falls related to mobility/balance problems. R17's interventions included: Reassess for standing lift when appropriate, keep bed in lowest position, and place wheelchair next to bed when in bed. Identified R17 wore a sling to left arm and required assistance with dressing, toileting and transfers.	2 830			

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2 830	Continued From page 4 R17's care sheet undated, identified staff were to place R17's wheelchair next to bed. Review of R17's progress notes from 12/14/24 to 12/15/24, identified the following: -12/14/24 at 2:40 p.m., NA was transferring R17 in a standing lift when R17 let go of the bar and NA lowered 17 to the floor, called for assistance and used a full body lift to place R17 into bed. -12/15/24 at 10:14 a.m., R17 complained of increased pain in left shoulder, Xray and sling to left shoulder were ordered. -12/15/24 at 12:58 p.m., Fracture to left Humeral head and neck. During an observation on 1/28/25 at 3:03 p.m., R17 was lying in bed and wheelchair was five feet from R17's bed facing the opposite direction. During an observation on 1/29/25 at 7:11 a.m., R17 was lying in bed and wheelchair was in the bathroom approximately 10 feet from R17's bed. During an interview on 1/29/25 at 7:15 a.m., nursing assistant (NA)-A stated R17 had a recent fall and broke her left arm. NA-A stated R17's wheelchair was to be placed next to R17's bed as a fall intervention. During an interview on 1/29/25 at 7:20 a.m., nurse manager (NM)-A verified R 17's bed was lying in bed and the wheelchair was in the bathroom which was approximately 10 feet from R17's bed. NM-A stated R17 was at risk for falls and had a recent fall with a fracture. NM-A further stated her expectation was that the wheelchair	2 830			

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2 830	Continued From page 5 would have been placed next to R17's bed. During an interview on 1/29/25 at 8:03 a.m., director of nursing (DON) verified R17 had a recent fall with a fracture. DON verified R17's wheelchair was to be placed next to the bed when R17 was in bed. DON stated her expectation was that the care plan would have been followed to help prevent future falls. Review of a facility policy titled Fall Prevention and Management Program Policy revised 4/21, identified all residents were to be assessed for fall risk and nursing staff would implement interventions according to resident specific risk factors. Further identified care plans would indicate the resident specific interventions to prevent falls SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, to assure proper assessment and interventions are being implemented and the provider is promptly notified of a change in condition. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830			
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and	2 850			3/4/25

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2 850	Continued From page 6 proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with personal hygiene for 4 of 4 residents (R7, R33, R267) reviewed for activities of daily living (ADL)'s. Findings include: R7 R7's quarterly Minimum Data Set (MDS) dated 11/19/24, identified R7 had severe cognitive impairment and had diagnoses which included renal insufficiency, dementia, and depression. Identified R7 required one person physical assist from staff with personal hygiene. R7's current care plan revised 2/27/24, indicated R7 had deficits with ADL's related to dementia and muscle weakness. Indicated R7 required staff assistance with personal hygiene and preferred to have staff assistance with removing facial hair. R7's annual comprehensive Care Area Assessment (CAA) dated 6/6/24, identified R7 required assistance with ADL's. Identified R7 had an activity intolerance related to weakness, physical limitations and dementia. R7's care sheet undated, identified it was a	2 850	Corrected		

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2 850	Continued From page 7 standard for staff to shave residents daily. During an observation on 1/27/25 at 1:18 p.m., R7 was sitting in her wheelchair in the day room and had several half inch long white facial hairs on her chin and above her upper lip. During an interview on 1/27/25 at 1:26 p.m., family member (FM)-A stated R7 preferred to be shaved when facial hair was visible. During an observation on 1/28/25 at 8:11 a.m., R7 was sitting in her wheelchair at the dining room table. R7 continued to have several half inch long white facial hairs on her chin and above her upper lip. During a joint interview on 1/28/25 at 8:51 a.m., nursing assistant (NA)-A and licensed practical nurse (LPN)-A verified R7 had several long white facial hairs. NA-A stated R7 required staff assistance to shave facial hair. NA-A stated she had not assisted R7 with shaving recently and was unsure the last time R7 had been shaved. LPN-A stated her expectation was that R7 would have been shaved as soon as facial hair was present. R33 R33's MDS dated 1/1/25, identified R33 had no cognitive impairment and diagnoses which included muscle weakness, depression, and diabetes. R33 required moderate assistance with personal hygiene such as combing hair and shaving. R33's care plan dated 12/26/24, revealed R33 had an activities of daily living (ADL) self-care performance deficits due to encephalopathy,	2 850			

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2 850	Continued From page 8 aspiration, urinary tract infection (UTI) dysphasia, and cognitive impairment. R33 wanted to be clean and well dressed. R33 required one assist for dressing, grooming, and hygiene. Care sheet titled pioneer park west dated 1/28/25, revealed stands of care: call light in reach, encourage use. Shave residents daily. During an interview on 1/27/25 at 12:30 p.m., R33 had approximately 2 cubic centimeters (cm) of facial hair on his chin, upper lip, and cheeks. During an observation on 1/28/25 at 8:47 a.m., R33 had 2 cm of facial hair on his chin, upper lip, and cheeks. . During an observation at 1/28/25 p.m. at 3:28 p.m., R33 had 2 cm of facial hair on his chin, upper lip, and cheeks. During an interview on 1/27/25 at 12:30 p.m., R33 reported his shaver did not work and was under the impression the facility requested residents buy their own shavers and did not want to spend money on a shaver. R33 had approximately 2 cubic centimeters (cm) of facial hair. During an interview on 1/28/25 at 3:28 p.m., nursing assistant (NA)-A verified R33 had long facial hair around 2 or 3 cm and needed to be shaved. NA-B verified that the care sheet stated to shave residents daily. NA-A stated shaving tasks did not get completed daily. NA-B indicated residents did not get shaved often. NA-B indicated that the facility had shavers for residents to sue however would have to ask a supervisor to obtain one since they were not kept in the storage room.	2 850			

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2 850	Continued From page 9 During an interview on 1/28/25 at 2:28 p.m., registered nurse (RN)-B indicated a resident should have been shaved on their shower day or shaved more often depending on the resident preference. R267 R267 quarterly MDS dated 11/23/24, identified R267 had no cognitive impairment and had diagnoses of malnutrition, hypertension, and vascular disease. R267 required maximal assistance with personally hygiene, including combing hair and shaving. R267 care plan revised on 11/22/24, revealed R267 had an ADL self-care performance deficit related to weakness, impaired mobility, self-care ability, severe malnutrition, dysphasia, and pain in legs. R267 wanted to be clean and well dressed. R267 needed assist of one for dressing, grooming, and hygiene. Care sheet titled pioneer park west dated 1/27/25, revealed Standards of care: call light in reach, encourage use. Shave residents daily. During an observation on 1/27/25 at 1:18 p.m., R267 had approximately 2 cubic centimeters (cm) of hair growth on his chin, upper lip, and cheeks. During an observation on 1/28/25 at 8:07 a.m., R267 had a razor sitting on his bedside table with 2-3 cm of hair growth on his on his chin, upper lip, and cheeks. During an observation on 1/29/25 at 7:58 a.m., R267 was laying in bed dressed ready to get up, R267 had approximately 3 cm of facial hair. Licensed practical nurse (LPN)-B and nursing	2 850			

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2 850	Continued From page 10 assistant (NA)-C entered the room and proceeded to assist R267 with ADLs. LPN-B then shaved R267. During an interview on 1/27/25 at 1:18 p.m., R267 indicated he was supposed to be shaved on Mondays once a week when he has his bath. R267 stated he liked to be shaved often. During an interview on 1/29/25 at 12:19 p.m., R267's daughter indicated R267 liked to be shaved often and did not want facial hair. R267 daughter had bought R267 two different razors. During an interview on 1/28/25 at 1:42 p.m., NA-D did not know how often R267 should have been shaved. NA-D verified that R267 had long facial hair around 3 cm and should have been shaved. R267 stated to NA-D, "I like my face shaved, I don't like a mustache." NA-D took out care sheet and verified R267 received a bath on Monday and that R267 would have to request to be shaved. During an interview on 1/28/25 at 2:52 p.m., director of nursing (DON) indicated R7 required staff assistance with shaving. DON stated her expectation was R7 would have been shaved when facial hair was present. During a follow-up interview on 1/28/25 at 4:38 p.m., DON stated the expectation was for staff to shave residents as needed. Staff were expected to do a body audit once a week with the shower and shave at that time if needed. The facility could have provided a razor if the resident did not have their own. A Facility policy titled Activities of Daily Living (ADL's) dated 3/15/21, indicated the facility would	2 850			

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2 850	Continued From page 11 have provided care and services for hygiene per the resident's individualized plan of care. Further indicated ADL care would have been provided based on resident preferences. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure all residents are shaved per their preference. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 850			
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with personal hygiene for 4 of 4 residents (R7, R33, R267) reviewed for activities of daily living (ADL)'s. Findings include: R7	2 920	Corrected	3/4/25	

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2 920	Continued From page 12 R7's quarterly Minimum Data Set (MDS) dated 11/19/24, identified R7 had severe cognitive impairment and had diagnoses which included renal insufficiency, dementia, and depression. Identified R7 required one person physical assist from staff with personal hygiene. R7's current care plan revised 2/27/24, indicated R7 had deficits with ADL's related to dementia and muscle weakness. Indicated R7 required staff assistance with personal hygiene and preferred to have staff assistance with removing facial hair. R7's annual comprehensive Care Area Assessment (CAA) dated 6/6/24, identified R7 required assistance with ADL's. Identified R7 had an activity intolerance related to weakness, physical limitations and dementia. R7's care sheet undated, identified it was a standard for staff to shave residents daily. During an observation on 1/27/25 at 1:18 p.m., R7 was sitting in her wheelchair in the day room and had several half inch long white facial hairs on her chin and above her upper lip. During an interview on 1/27/25 at 1:26 p.m., family member (FM)-A stated R7 preferred to be shaved when facial hair was visible. During an observation on 1/28/25 at 8:11 a.m., R7 was sitting in her wheelchair at the dining room table. R7 continued to have several half inch long white facial hairs on her chin and above her upper lip. During a joint interview on 1/28/25 at 8:51 a.m., nursing assistant (NA)-A and licensed practical	2 920			

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2 920	Continued From page 13 nurse (LPN)-A verified R7 had several long white facial hairs. NA-A stated R7 required staff assistance to shave facial hair. NA-A stated she had not assisted R7 with shaving recently and was unsure the last time R7 had been shaved. LPN-A stated her expectation was that R7 would have been shaved as soon as facial hair was present. R33 R33's MDS dated 1/1/25, identified R33 had no cognitive impairment and diagnoses which included muscle weakness, depression, and diabetes. R33 required moderate assistance with personal hygiene such as combing hair and shaving. R33's care plan dated 12/26/24, revealed R33 had an activities of daily living (ADL) self-care performance deficitsdue to encephalopathy, aspiration, urinary tract infection (UTI) dysphasia, and cognitive impairment. R33 wanted to be clean and well dressed. R33 required one assist for dressing, grooming, and hygiene. Care sheet titled pioneer park west dated 1/28/25, revealed stands of care: call light in reach, encourage use. Shave residents daily. During an interview on 1/27/25 at 12:30 p.m., R33 had approximately 2 cubic centimeters (cm) of facial hair on his chin, upper lip, and cheeks. During an observation on 1/28/25 at 8:47 a.m., R33 had 2 cm of facial hair on his chin, upper lip, and cheeks. . During an observation at 1/28/25 p.m. at 3:28 p.m., R33 had 2 cm of facial hair on his chin,	2 920			

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2 920	Continued From page 14 upper lip, and cheeks. During an interview on 1/27/25 at 12:30 p.m., R33 reported his shaver did not work and was under the impression the facility requested residents buy their own shavers and did not want to spend money on a shaver. R33 had approximately 2 cubic centimeters (cm) of facial hair. During an interview on 1/28/25 at 3:28 p.m., nursing assistant (NA)-A verified R33 had long facial hair around 2 or 3 cm and needed to be shaved. NA-B verified that the care sheet stated to shave residents daily. NA-A stated shaving tasks did not get completed daily. NA-B indicated residents did not get shaved often. NA-B indicated that the facility had shavers for residents to use however would have to ask a supervisor to obtain one since they were not kept in the storage room. During an interview on 1/28/25 at 2:28 p.m., registered nurse (RN)-B indicated a resident should have been shaved on their shower day or shaved more often depending on the resident preference. R267 R267 quarterly MDS dated 11/23/24, identified R267 had no cognitive impairment and had diagnoses of malnutrition, hypertension, and vascular disease. R267 required maximal assistance with personally hygiene, including combing hair and shaving. R267 care plan revised on 11/22/24, revealed R267 had an ADL self-care performance deficit related to weakness, impaired mobility, self-care ability, severe malnutrition, dysphasia, and pain in	2 920			

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2 920	Continued From page 15 legs. R267 wanted to be clean and well dressed. R267 needed assist of one for dressing, grooming, and hygiene. Care sheet titled pioneer park west dated 1/27/25, revealed Standards of care: call light in reach, encourage use. Shave residents daily. During an observation on 1/27/25 at 1:18 p.m., R267 had approximately 2 cubic centimeters (cm) of hair growth on his chin, upper lip, and cheeks. During an observation on 1/28/25 at 8:07 a.m., R267 had a razor sitting on his bedside table with 2-3 cm of hair growth on his on his chin, upper lip, and cheeks. During an observation on 1/29/25 at 7:58 a.m., R267 was laying in bed dressed ready to get up, R267 had approximately 3 cm of facial hair. Licensed practical nurse (LPN)-B and nursing assistant (NA)-C entered the room and proceeded to assist R267 with ADLs. LPN-B then shaved R267. During an interview on 1/27/25 at 1:18 p.m., R267 indicated he was supposed to be shaved on Mondays once a week when he has his bath. R267 stated he liked to be shaved often. During an interview on 1/29/25 at 12:19 p.m., R267's daughter indicated R267 liked to be shaved often and did not want facial hair. R267 daughter had bought R267 two different razors. During an interview on 1/28/25 at 1:42 p.m., NA-D did not know how often R267 should have been shaved. NA-D verified that R267 had long facial hair around 3 cm and should have been shaved. R267 stated to NA-D, "I like my face	2 920			

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2 920	Continued From page 16 shaved, I don't like a mustache." NA-D took out care sheet and verified R267 received a bath on Monday and that R267 would have to request to be shaved. During an interview on 1/28/25 at 2:52 p.m., director of nursing (DON) indicated R7 required staff assistance with shaving. DON stated her expectation was R7 would have been shaved when facial hair was present. During a follow-up interview on 1/28/25 at 4:38 p.m., DON stated the expectation was for staff to shave residents as needed. Staff were expected to do a body audit once a week with the shower and shave at that time if needed. The facility could have provided a razor if the resident did not have their own. A Facility policy titled Activities of Daily Living (ADL's) dated 3/15/21, indicated the facility would have provided care and services for hygiene per the resident's individualized plan of care. Further indicated ADL care would have been provided based on resident preferences. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to activities of daily living. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing assistance with activities of daily living. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 920			

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21290	Continued From page 17	21290	Corrected	3/4/25	
21290	MN Rule 4658.0710 Subp. 3 A AdmissionOrders & Physician Evaluations Subp. 3. Frequency of physician evaluations. A. A resident must be evaluated by a physician at least once every 30 days for the first 90 days after admission, and then whenever medically necessary. A physician visit is considered timely if it occurs within ten days after the date the visit was required. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure newly admitted residents received 30 day physician visits for the first 90 days for 1 of 1 residents (R30) reviewed for 30 day physician visits. Findings include: R30's admission Minimum Data Set (MDS) dated 12/1/24, identified R30 had no cognitive impairment and had diagnoses which included chronic kidney disease (CKD), an indwelling catheter, and a history of urinary tract infections. R30 required moderate assistance with activities of daily living (ADL's) bathing, transfers, and toileting. R30's facesheet indicated R30 was admitted to the facility on 11/25/24. R30's medical record lacked evidence R30 was seen by a physician since admission. During an interview on 1/27/25 at 6:29 p.m., R30				

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21290	Continued From page 18 stated he had not seen a physician since he was admitted to the facility. R30 further stated he had requested to see a physician and staff avoided him when he asked. R30 indicated he had seen a nurse practitioner however had wanted to see a physician. During an interview on 1/29/25 at 10:08 a.m., nurse manager (NM)-B stated R30 had been seen three times by a nurse practitioner (NP) since admission however, R30 had not been seen by a physician since admission. During an interview on 1/29/25 at 10:38 a.m., administrator and director of nursing (DON) confirmed the above findings. Administrator stated her expectations were residents received physicians visits every 30 days for the first 90 days after admission. Review of facility policy titled Physicians Services, modified 11/19, the frequency of physicians visits would consist of at least every 30 days for the first 90 days after admission. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures so resident receive timely physician visits. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure residents receive physician visits at the required intervals. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21290			
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General	21435			3/4/25

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21435	Continued From page 19 Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meaningful and engaging activities for 1 of 1 residents (R62) reviewed for activities. Findings include: R62's significant change Minimum Data Set (MDS) dated 12/24/24, identified R62 had no cognitive impairment and had diagnoses which included depression, failure to thrive and was currently receiving hospice services. R62 required extensive assistance with activities of daily living (ADL's) which include bed mobility, transfers, and toileting. R62's LTC therapeutic recreation and activities assessment dated 12/24/24, indicated R62 preferred day/activity room and independent activities in her room. R62's preferences were visits from her daughter, talking with staff, watching television, one to one visits, and	21435	Corrected		

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21435	Continued From page 20 activities in a group setting. R62's care plan revised 12/30/24, identified R62 had a long term goal to choose her own activities. R62's careplan further indicated R62 was to be invited to scheduled activities, provided an activities calendar, and provided supplies to pursue her activity interests. During an observation and interview on 1/27/25 at 5:03 p.m., R62 stated she had not been offered any visitors throughout the day and was feeling very sad. R62 further sated she had not been offered any activities since she was admitted. R62 indicated she did not remember seeing an activities calendar in her room. A scan of the room was completed and no activities calendar was noted. During an observation and interview on 1/28/25 at 12:11 p.m., R62 was laying in her bed using her personal cellular telephone. R62 continued to state she did not have an activities calendar in her room and had never received one for the month of January 25. R62 stated she had no way of knowing what activities were going on in the facility. R62 verbalized that she not had any visitors today. R62 stated "this is what I do all day, just lay here in this bed". R62 further stated she wished she had an activities calendar, was invited to actives throughout the day, and had visits from the staff. During an interview on 1/28/25 at 12:28 p.m., nursing assistant (NA)-F stated the life enrichment team was in charge of handing out activity calendars to each resident. NA-F further stated the life enrichment team had daily activities in the community room and R62 enjoyed attending them at times.	21435			

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21435	Continued From page 21 During an interview on 1/28/25 at 2:38 p.m., life enrichment director (LED) confirmed calendars were handed out to each resident on the first of every month. LED stated life enrichment staff were expected to go to R62's room and invite her to group activities. LED further stated she was not aware R62 did not have an activities calendar in her room and that R62 had not been invited to any group activities. LED indicated staff do not document when a resident completed an activity so she had no way of knowing what activities R62 had been invited to. LED confirmed R62's activity interests. During an interview on 1/29/25 at 10:33 a.m., director of nursing confirmed the above findings and stated no documentation was completed to indicate residents received activities throughout the day. DON stated her expectation was staff were to invite and engage all resident in daily activities. Requested facility for the Activities Program, however, one was not provided. SUGGESTED METHOD OF CORRECTION: The activity director could train all staff to ensure each resident's assessed activity preferences are honored, and then audit to ensure this is occurring. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21435			
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five	21545			3/4/25

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21545	Continued From page 22 percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation	21545			

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21545	Continued From page 23 must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility had a 7% percent medication error rate for 2 of 4 residents(R61, R44) observed during medication administration. Findings Include: R61 R61's admission Minimum Data Set (MDS) dated 1/5/25, identified R61 had moderate cognitive impairment and diagnoses which included: Crohn's disease (chronic condition that causes inflammation of gastrointestinal tract), heart failure and chronic kidney disease. R61's Discharge Orders And Information hospital form dated 12/30/24, included the following: -Creon 24000-76000 units oral capsule, take one capsule by mouth three times daily. During an observation on 1/27/25 at 4:38 p.m. trained medication aide (TMA)-A set up R61's medications. TMA-A indicated R61 was to receive Creon (medication that replaced digestive enzymes in body) however it was not available, so she would contact the pharmacy to order it again. R44 R44's admission MDS dated 11/21/24, identified R44 was cognitively intact, and had diagnoses which included: arthritis, sciatica right side (pain	21545	Corrected		

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21545	Continued From page 24 that travels nerve from buttocks down leg) and other low back pain. R44's Order Summary Report signed and dated 1/23/25, included the following: -Lidocaine External Patch 5% apply to back topically in the morning for pain. on for 12 hours, off for 12 hours and remove per schedule. Order date 1/16/25. During an observation on 1/29/25, at 7:21 a.m., TMA-A set up R44's medications which included: Lidocaine patch labeled: 4%, apply 1 patch every day for 12 hours and leave off for 12 hours. TMA-A indicated the order was for a Lidocaine 5% patch, but stated the nurse had called the pharmacy and they did not have 5% Lidocaine so they sent the Lidocaine 4% patches instead. At 7:39 a.m., TMA-A entered R44's room, and administered medications, which included applying the Lidocaine 4% patch to R44's lower back. During an interview on 1/28/25 at 10:16 a.m., clinical coordinator registered nurse (RN)-B confirmed R61's Creon was not available, and not administered since 1/22/25. RN-B indicated the facility's usual process was to reorder medication if out from pharmacy. RN-B stated she would need to contact director of nursing (DON) to see if anything else should be done. During a follow up interview on 1/29/25 at 8:45 a.m., RN-B stated TMA-A had informed her that R44's Lidocaine administered was not the correct dosage. RN-B confirmed that R44's Lidocaine patch order had recently been updated to 5% instead of 4%. RN-B indicated the facility health unit coordinator (HUC) entered orders into the electronic health record, which was verified by a nurse, then faxed the pharmacy. RN-B stated it was important that	21545			

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21545	Continued From page 25 R44 received the correct Lidocaine patch dosage, for pain relief and to administer medications as ordered. During a telephone interview on 1/28/25 at 12:37 p.m. pharmacy consultant (PC)-A stated the expectation was if a resident was out of a medication, to contact the pharmacy, and if not available to try a different pharmacy. PC-A also expected the facility to contact the physician to see if the medication should be held until received, or if a different medication should be administered, and document. C-A stated that if R61 did not have Creon as ordered, R61 could have gastrointestinal (GI) upset. During a joint interview on 1/28/25 at 2:56 p.m., with director of nursing (DON) and medical director (MD), DON stated facility's usual process if a medication was not available to administer, the TMA would inform the nurse, the pharmacy would be called and a refill form would be completed. DON confirmed she had been made aware earlier that day that R61 had been out of Creon medication since 1/22/25. DON stated they had discovered it was an insurance reason why R61's Creon medication had not been sent, and the that the facility would be purchasing the medication for R61, to be available. MD stated he would expect the resident's provider would be contacted if a medication was not available to administer, so they could determine if the resident could wait for the medication to be filled, or if it needed to be urgently refilled. During a follow up interview on 1/29/25 at 10:04 a.m., DON verified R44's lidocaine 5% patch order was updated on 1/16/25, with a start date of 1/17/25. DON stated the facility's usual practice for new orders included the HUC to transcribe the	21545			

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21545	Continued From page 26 orders, a nurse confirmed the order, then HUC would send order to pharmacy. DON indicated her expectation was for TMA-A to follow the facility's policy for medication checks before administering the patch. The facility policy titled Medication Administration Policy revised 5/21, identified the policy was to ensure safe, effective and timely drug therapy, to provide for an accurate and concise documentation system. Medication Administration procedure identified: the eight rights of drug administration would be followed when administering all medications: right resident, right drug, right dose, right dosage form, right route, right time, right reason and right documentation. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly administered. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21545			
21550	MN Rule 4658.1325 Subp. 1 Adminiattration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services.	21550			3/4/25

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00973	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2025
NAME OF PROVIDER OR SUPPLIER FLAGSTONE		STREET ADDRESS, CITY, STATE, ZIP CODE 12500 CASTLEMOOR DRIVE EDEN PRAIRIE, MN 55344			
(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) COMPLETE DATE
21550	Continued From page 27 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement a system to ensure medications were available to administer as ordered for 2 of 2 residents (R61, R57) identified who did not receive medications as ordered. Findings Include: R61 R61's admission Minimum Data Set (MDS) dated 1/5/25, identified R61 had moderate cognitive impairment and diagnoses which included: Crohn's disease (chronic condition that causes inflammation of gastrointestinal tract), heart failure and chronic kidney disease. During an observation on 1/27/25 at 4:38 p.m., trained medication aide (TMA)-A set up R61's medications. TMA-A indicated R61 was to receive Creon (medication that replaces digestive enzymes in body) however it was not available to administer, so would contact the pharmacy to order it again. R61's Discharge Orders And Information hospital form dated 12/30/24, included the following: -Creon 24000-76000 units oral capsule, take one capsule by mouth three times daily. R61's January Electronic Medication Administration Record (EMAR) identified the following: -Creon Oral Capsule Delayed Release Particles 24000-76000 Unit. Give 1 capsule by mouth with meals for pancreatic insufficiency, from January 22 at 1200 p.m. to January 28 at 8:00 a.m., it was	21550	Corrected		

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21550	Continued From page 28 not administered 18 times. Review of R61's progress notes from 1/22/25, to 1/27/25, identified the following: -1/24/25 at 5:05 p.m., Creon Oral Capsule, no supply, called pharmacy and informed nurse. -1/27/25 at 4:46 p.m., Creon Oral Capsule, need to be reordered. R61's progress notes lacked documentation R61's provider had been notified R61's Creon medication was not available. During an interview on 1/28/25 at 10:16 a.m., clinical coordinator registered nurse (RN)-B confirmed R61's Creon was not available, and had not been administered since 1/22/25. RN-B stated she became aware that morning that R61 was out of Creon medication, and would make sure it was available to give later that day. RN-B indicated the facility's usual process was to reorder medication when the medication ran out from pharmacy. RN-B stated she would need to contact director of nursing (DON) to see if anything else could be done. During a telephone interview on 1/28/25 at 12:37 p.m., pharmacy consultant (PC)-A stated the expectation was if a resident was out of a medication, to contact the pharmacy, and if not available to try a different pharmacy. PC-A also expected the facility to contact the physician to see if the medication should be held until received, or if a different medication should be administered, and document. PC-A stated that if R61 did not have Creon as ordered, R61 could have gastrointestinal (GI) upset. PC-A indicated if a resident did not receive Zolofl as ordered, they may be fine, or it may affect their depression, or cause anxiety.	21550			

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21550	Continued From page 29 During a telephone interview on 1/28/25, at 11:54 p.m., nurse practitioner (NP)-A confirmed she was familiar with R61's care and had not been notified R61 was not receiving Creon as ordered. NP-A stated if R61 did not have Creon medication available to administer, her expectation was that pharmacy would be notified, and if still unavailable that she or triage would be contacted because it was important residents receive their medications as prescribed. During a follow up interview on 1/29/25 at 8:45 a.m., RN-B stated R61's Creon had been ordered and would be delivered that day. RN-B indicated they notified R61's provider of R61's missed Creon medication, and they spoke to PC-A who advised them to monitor for possible effects of gastrointestinal symptoms from R61 not receiving receiving the Creon as ordered, so R61 would be monitored. R57 R57's quarterly MDS dated 12/11/24, identified R57 had moderate cognitive impairment and diagnoses which included: hypertension, depression Alzheimer's, aphasia, and seizure disorder. During an observation on 1/28/25 at 9:01 a.m., TMA-E went to set up R57 medications. TMA-E went to take Zoloft (for depression) 25 Milligram (mg) out of the medication cart. TMA-E was unable to locate the medication in the medication cart. TMA-E indicated the medication could have been in the medication room and would check and if unable to locate the medication, then the pharmacy would be contacted.	21550			

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21550	Continued From page 30 During an interview on 1/28/25 at 1:46 p.m., TMA-E verified that R57 did not have the Zoloft medication in the medication cart but was able to locate the medication in the medication room and was able to give the medication. TMA-E indicated the process would be to reorder the medication according to the date on the medication card. If a resident missed a medication the facility would make the pharmacy aware the medication was currently out and needed to be refilled. The nurse was responsible for updating the physician on the missed medication dose. TMA-E verified the EMAR reflected R57 and did not receive Zoloft 25 mg on 1/26/25 and 1/27/25. Review of the EMAR revealed that R57 did not receive Zoloft 25 mg on 1/26/25 and 1/27/25. Review of the signed physician orders signed 1/27/25 revealed R57 had an order for Zoloft 25 mg, take one tablet by mouth daily. After review of the progress notes from 1/25/25 to 1/27/25, revealed the pharmacy and physician were not updated that R57 missed two doses of Zoloft 25 mg. During an interview on 1/28/25 at 2:52 p.m., RN-B indicated the facility process to reorder medication was to pull the sticker on the medication card when the medication was low and fax the sticker to the pharmacy. It was the responsibility of the floor nurse to let the provider know a medication dose was missed. RN-B indicated she was unaware R57 had missed two doses of Zoloft 25 mg on 1/26/25 and 1/27/25. During a joint interview on 1/28/25 at 2:56 p.m. with director of nursing (DON) and medical director (MD), DON stated facility's usual process	21550			

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21550	Continued From page 31 was a medication was not available to administer, the TMA would inform the nurse, the pharmacy would be called and a refill form would be completed. DON confirmed she had been made aware earlier that day that R61 had been out of Creon medication since 1/22/25. DON stated they had discovered it was an insurance reason why R61's Creon medication had not been sent, and the facility would be purchasing the medication for R61, so would be available. MD stated he would expect the resident's provider would be contacted if a medication was not available to administer, so they could determine if the resident could wait for the medication to be filled, or if it needed to be urgently refilled. MD stated R61's Creon was not a life threatening medication, they had assessed R61, who did not have diarrhea, which could have been a symptom of not receiving the Creon, so he felt R61 had not suffered consequences of not receiving the medication. DON also confirmed R57 had been out of Zoloft medication to administer, but the medication was now available. MD stated R57 did not suffer any consequences of the two missed Zoloft doses as 25 mg. was a low dose. The facility policy titled Medication Administration Policy revised 5/21, identified the policy was to ensure safe, effective and timely drug therapy, to provide for an accurate and concise documentation system. The policy included that the eight rights of drug administration would be followed when administering all medications: right resident, right drug, right dose, right dosage form, right route, right time, right reason and right documentation. The policy included instruction to fax or call the pharmacy for medications, and if medication was not available the emergency kit may be used according to policy. The policy did not identify instruction of what to do if medication	21550			

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21550	Continued From page 32 was not available to administer from the emergency kit, or to notify the resident's provider if a medication was not available to administer. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable procedures for re-ordering medications to ensure quality; then inservice applicable staff members and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21550			
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the resident's ability to self-administration of medications (SAM) was assessed prior to leaving medications with the resident for 3 of 3 residents (R33, R267, R9) reviewed who had medications in their rooms. R33 R33's admission Minimum Data Set (MDS) dated 1/1/25, identified R33 had no cognitive impairment and diagnoses which included: muscle weakness, depression, and diabetes. R33	21565	Corrected		3/4/25

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21565	Continued From page 33 required moderate assistance with personal hygiene such as combing hair and shaving. R33's care plan dated 12/26/24, revealed R33 had an activity of daily living (ADL) self-care performance deficits due to encephalopathy, aspiration, urinary tract infection (UTI) dysphasia, and cognitive impairment. R33 wanted to be clean and well-dressed. R33 required one assist for dressing, grooming, and hygiene. The care plan lacked information regarding self-administration of medication or medications that were kept in the resident's room. During an observation on 1/27/25 at 12:41 p.m., Nystatin powder (medication used to treat fungal skin infections) was located on the table next to the bed. R33 indicated his Nystatin powder is always there. Review of orders dated 1/21/25 revealed an order for Nystatin 1000 units/gram powder applied topically daily and twice a day as needed. No order to leave medication at bedside. Review of assessments revealed a lack of an assessment to self-administer medication. During an interview on 1/27/25 at 6:21 p.m., registered nurse (RN)-A, verified Nystatin power was on the side table next to the bed. RN-A indicated it must have been left out by mistake and removed the Nystatin powder. RN-A locked up the Nystatin powder in the medication cart. During an interview on 1/28/25 at 8:41 a.m., RN-B indicated Nystatin powder should not be have been left on the nightstand as it was a medication. RN-B verified R33 did not have an order for medications to be left at the bedside.	21565			

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21565	Continued From page 34 R267 R267 quarterly MDS dated 11/23/24, identified R267 had no cognitive impairment and diagnoses of malnutrition, hypertension, and vascular disease. R267 required maximal assistance with personal hygiene including combing hair and shaving. R267's care plan revised on 11/22/24, revealed R267 chose not to self-administer medications. Care plan directed staff to administer medications per orders. During an observation on 1/28/25 at 12:19 p.m., R267 had refresh eye drops (for dry eyes) present on the side table. On the nightstand, R267 had one bottle of Tums (treatment for heartburn) 1000 mg, one bottle of antacids (used to neutralize acid in the stomach), one roller-ball anti-itch hydrocortisone (decrease inflammation/ itchy skin), and one hydrocortisone 1% cream (a cream to treat skin conditions such as itchy or inflamed skin). Review of signed orders dated 1/24/25, revealed R267 did not have orders for medications to be left at bedside. R267 did not have an order for Tums or refresh eye drops. R267 did have an order for hydrocortisone cream however, no order for the medication to be left at the bedside. Review of the electronic medication administration record (EMAR) for January 2025, revealed hydrocortisone cream 2.5% apply to perineal area topical two times per day, order start date of 1/20/24. No self-administration order or order to be left in the room was noted. No order for Tums, antacids, or refresh eye drops on	21565			

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21565	Continued From page 35 the EMAR. Further review of EMAR for January 2025, revealed, artificial tears ophthalmic solution 0.1-0.3 %, install 1 drop in both eyes as needed for dry eyes, four times a day. Medication was discontinued on 1/20/25. Review of assessments revealed R267 did not have an assessment to self-administer medications. During an interview on 1/28/25 at 2:42 p.m. licensed practical nurse (LPN)-B confirmed R267 had no orders for medications to be left at the bedside. LPN-B confirmed eye drops were on the side table, one bottle of Tums 100 mg, one bottle of antacids, one roller-ball anti-itch hydrocortisone, and one hydrocortisone 1% cream on the nightstand. Progress note from 1/28/25 at 8:09 p.m., revealed: resident was found to have one bottle of Tums, one bottle of antacids, one roller-ball anti-itch, hydrocortisone tube and refresh eye drops in the room. Writer explained why we could not let him keep the medication in there, and that they would be given to his daughter to take home. Writer then called the daughter to explain the situation and let her know that nurse practitioner would be informed and see if at all possible to have these medications ordered as needed so facility staff could administer them. R9 R9's MDS dated 1/2/25, identified R9 had no cognitive impairment and needed moderate assistance with activities of daily living. R9 had diagnoses which included hypertension, arthritis,	21565			

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21565	Continued From page 36 and pain in right leg. During an observation on 1/27/25 at 12:13 p.m., Aspercream with lidocaine (medication used for pain relief) was noted on the bedside table. During an observation on 1/28/25 at 8:54 a.m., Aspercream with lidocaine continued to be next to the bed on the bedside table. During an observation on 1/28/25 at 12:28 p.m., aspercream with lidocaine continued to be next to the bed on the bedside table. R9 care plan revised on 10/7/24, revealed R9 chose not to self-administer medications, except for aspercream. Review of R9's assessments revealed R9 did not have an assessment to self-administrator medications. Review of signed orders dated 11/12/24, revealed aspercream lidocaine external cream 4% (for pain relief) apply to affected area(s) topically as needed for pain apply 2 grams twice a day to painful area and apply to lower legs topical in the morning for pain apply two grams to each lower leg before compression stockings. No orders for self-administration of medications was noted. Review of EMAR for January 2025, revealed staff signed off the administration of Aspercream Lidocaine external cream 4% apply to lower legs topically in the morning for pain apply two grams to each lower leg before compression stockings, order start date was 12/12/23. EMAR lacked orders to leave medication at bedside. During an interview on 1/27/25 at 12:13 p.m., R9	21565			

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21565	Continued From page 37 stated she kept the aspercream with lidocaine at the bedside otherwise R9 would forget to apply it. R9 indicated the cream had always been on the bedside table. During an interview on 1/27/25 at 6:19 p.m., RN-A reported the nurse would complete the self-administration order for a resident to self-administrate a medication in their room. RN-A revealed staff put on the aspercream for R9. RN-A verified R9 did not have an order to self-administer the medications. RN-A verified R9 did not have a self-administration assessment completed. RN-A verified that R9 had aspercream with lidocaine was left on her bedside table. During a follow-up interview on 1/28/25 at 4:41 p.m. director of nursing (DON) indicated if a resident was assessed to be able to self-administer medications, it would have been identified in the care plan, otherwise medications were kept in the medication cart. DON verified R33, R267 and R9 did not have self-administration assessments completed. A policy titled Medication Administration Policy dated May 2021 revealed Procedure: 17. Medication would not be left at beside unless resident had an order for self-administration of medications and had been assessed to be safe to do so and the care plan reflected the resident's ability. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure residents are assessed timely with self administration of medications; then provide staff education. The quality assurance committee	21565			

Minnesota Department of Health

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21565	Continued From page 38 could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 13, 2025

Administrator
Flagstone
12500 Castlemoor Drive
Eden Prairie, MN 55344

RE: CCN: 245312
Cycle Start Date: January 29, 2025

Dear Administrator:

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

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 13, 2025

Administrator
Flagstone
12500 Castlemoor Drive
Eden Prairie, MN 55344

Re: Reinspection Results
Event ID: M4TH12

Dear Administrator:

On March 12, 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 January 29, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us