



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 12, 2025

Administrator
Gundersen St. Elizabeth's Care Center
1200 Fifth Grant Boulevard West
Wabasha, MN 55981

RE: CCN: 245487

Cycle Start Date: May 21, 2025

Dear Administrator:

On July 23, 2025, Center for Medicare & Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed enforcement remedies.

The Minnesota Department of Health completed a revisit on August 19, 2025, and the Minnesota Department of Public Safety completed a revisit on August 6, 2025, and a Federal Monitoring visit on August 6, 2025, to confirm that your facility had attained and maintained compliance. Based on our visits, we have determined that your facility has achieved substantial compliance.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 21, 2025, did not go into effect. (42 CFR 488.417 (b))

The delay in receiving this notification is the result of an iQIES IT issue, which has now been resolved. Thank you for your patience.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Freeman Building | HRD-OLF 3B
625 Robert St. N.

P.O. Box 64975

St. Paul, MN 55164-0899

Office: 651-201-4384 | Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 4, 2025

Administrator
Gundersen St. Elizabeth's Care Center
1200 Fifth Grant Boulevard West
Wabasha, MN 55981

RE: CCN: 245487
Cycle Start Date: May 21, 2025

Dear Administrator:

On May 21, 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:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor

Rochester District Office

Health Regulation Division

Minnesota Department of Health

3425 40th Avenue NW, Suite 115

Rochester, MN 55901

Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 21, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 21, 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:

Gundersen St Elizabeth's Care Center

June 4, 2025

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245487	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER GUNDERSEN ST ELIZABETH'S CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981		
(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 000	INITIAL COMMENTS On 5/19/25 to 5/21/25, a standard recertification survey was conducted at your facility. In addition, a complaint investigation was also completed. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed with no deficiency issued: H54874887C (MN109615) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 605 SS=E	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3) (d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 605			7/31/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/13/2025

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

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F 605	Continued From page 1 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- . . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences	F 605			

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F 605	Continued From page 2 which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be	F 605			

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F 605	Continued From page 3 renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop and implement a system to ensure ongoing, adequate monitoring for side effects with consumed psychotropic medications to promote continuity of care for 3 of 5 residents (R39, R56, R9); and failed to ensure the use of as-needed (i.e., PRN) psychotropic medication was limited to 14-days or extended to a certain date with supporting rationale provided by the medical provider for 1 of 5 residents (R31) reviewed for unnecessary medication use. Findings include: SIDE EFFECT MONITORING: R39 R39's annual Minimum Data Set (MDS) assessment dated 4/18/25, identified R39 had intact cognition and demonstrated no delusional thinking during the review period. Further, the MDS outlined R39 consumed both antianxiety and antidepressant medications. R39's Medical Plan of Care, dated 4/29/25, identified R39's medications and nursing orders with their corresponding start date(s). This identified R39 as being over 90 years old and having active orders for multiple psychotropic medications including: Wellbutrin (antidepressant) 300 milligrams (mg) daily with a start dated recorded 4/13/23; Trazodone			F 605	EHR (ECS) medication administration record (MAR) order entries for daily monitoring and observing for commonly seen side effects of each psychotropic (antidepressant, antipsychotic, antianxiety and hypnotic) medication class completed for R39, R56, R9 and R31 by 5/31/2025. All current residents' medical plan of care reviewed to identify any psychotropic (antidepressant, antipsychotic, antianxiety and hypnotic) medication use. EHR MAR order entries for daily monitoring and observing for commonly seen side effects of each psychotropic medication class completed by 6/30/2025. R56' orthostatic blood pressure (lying and sitting) completed by 6/13/2025. R56 unable to stand for long periods of time and requires use of a mechanical lift and two staff assist. R56 seen by mental health provider 6/10/25 and antipsychotic medication placed on hold as part of original gradual dose reduction plan. All current residents' medical plan of care reviewed to identify any residents receiving antipsychotic medications and order for every 60-day orthostatic blood pressure monitoring entered in EHR, with start date of 6/10/2025. Policies "Psychotropic Medication",		

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F 605	Continued From page 4 (antidepressant) 50 mg twice daily (plus another 25 mg dose in the morning) with a start date recorded 6/21/24; Mirtazapine (antidepressant) 15 mg every bedtime with a start date recorded 9/26/24; and Lexapro (antidepressant) 15 mg daily with a start date recorded 3/25/25. On 5/21/25 at 7:57 a.m., R39 was observed seated in a recliner chair while in her room. R39 was interviewed and recalled consuming several medications for depression including Ativan and trazodone stating she felt, overall, the medications were fine but added aloud, "They're going pretty good but I'm awfully tired." R39 stated she had felt "really tired" for the past several months and denied any other potential side effects of the medications. R39 stated staff were aware of her feeling tired and reiterated aloud, "The Ativan and trazodone are the two that really make me sleepy." R39's most recent Behavioral Health Consultant - Follow Up note, dated 1/2025, identified R39 was seen by an outside consultant for her mental and/or behavioral health needs at the care center. The note outlined R39 had sustained a fall that morning without injury and recalled the recent Holiday season. R39's family member stopped by during the visit and the note outlined, "We discussed today patient's current status of anxiety as we have been monitoring this for the last several months. Patient expresses concern over sleepiness but has agreed it is in her best interest to maintain her current level of medication as it has been more comfortable than the feeling of anxiety." The note outlined some methods to help reduce anxiety for R39, such as more out-of-room activities, and concluded with dictation, "Orders Placed," and, "None." The	F 605	"Consultant Pharmacist" reviewed and revised, as applicable, by 6/30/2025 and presented at the July 9, 2025 QAPI meeting for approval. Communication to staff in daily clinical huddle notes (weekdays 5/30/2025-6/9/2025) provided about changes to the facility process for monitoring for side effects of psychotropic medications. Nursing Team meetings conducted 5/21/2025, 5/22/2025, 6/3/2025 that included a review of the change to process for psychotropic medication side effect monitoring. Director of Nursing (or designee) to conduct random audits of at least 5 current or new residents identified as being on any psychotropic medication to verify that side effect monitoring has been initiated or continues x 3 months (July, August, September 2025). Deficient practices identified during the MDH survey reviewed and preliminary plan of correction were discussed and reviewed with IDT at June 11th, 2025 QAPI meeting.		

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F 605	Continued From page 5 completed note lacked any review of what, if any, potential side effects of the multiple consumed psychotropics were discussed, reviewed or evaluated with R39. When interviewed on 5/21/25 at 8:01 a.m., nursing assistant (NA)-F stated R39 was usually "very anxious" in the morning hours and would calm down as the day progressed adding R39 would often report she "doesn't feel good" and of being tired. NA-F stated R39 took medication to help her anxiety but the NA(s) don't record anything in the record about that such as symptoms or interventions, rather, they just "pass it on to the nurses." NA-F stated they had never heard R39 complain about medication side effects before, but acknowledged R39 often reported being tired adding she "enjoys lights off" in her own room. R39's record included a series of notes labeled, "BEHAVIOR MONITORING/PSYCHOTROPIC MEDICATION USE ASSESSMENT," and were dated 10/2024, 3/2025, and 4/2025. These notes outlined R39's psychotropic medications were adjusted in 10/2024 and 3/2025, and listed R39's current psychotropic medication regimen and interventions to address potential behaviors. The note dated 4/2025, identified a comprehensive registered nurse (RN) evaluation was completed, and recorded R39 as alert and oriented adding, "... is her own person with decision making." R39's medications were listed and included Wellbutrin XL, Trazodone, Ativan and mirtazapine. The note outlined, "Resident will state on a near daily basis that she doesn't feel good or that she is tired, generally she does well participating in activities and walking to the dining room to eat." However, all of these completed notes lacked evidence	F 605			

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F 605	Continued From page 6 what, if any, potential side effects of the consumed psychotropic medications were being monitored or evaluated. R39's ADL Care Plan, dated 4/17/25, identified R39 was independent with ambulation and used a walker. A section labeled, "Behaviors," identified R39 was anxious and would, at times, complain about a "crawling stomach." R39's corresponding Care Plan, printed 5/19/25, identified R39's outlined problem statements, goals, and interventions along with date of onset and/or revision. This care plan identified, "BEHAVIORS ... may become very anxious and tearful, please reassure/redirect me as needed; provide 1:1 when able and PRN medication (if still available) when other interventions ineffective." The care plan continued, "Nurses ----- I receive scheduled Wellbutrin XL, Lexapro and Trazodone and Ativan to help manage depressive symptoms and anxiety ... administer as ordered and observe for effectiveness ... Observe for potential s/s [signs] increased depressive symptoms ... update NM/MD as needed." However, both of these provided care plans lacked what, if any, potential medication side effects were identified for R39 or being monitored despite R39 consuming multiple psychotropic medications. R39's Med Pass AM flowsheet, dated 5/2025, identified R39's current physician-ordered medications and staff initials to demonstrate their administration and/or refusal. This identified current orders for Wellbutrin, trazodone, Ativan, and Lexapro with no refusals recorded. In addition, R39's corresponding Treatments/All flowsheet, dated 5/2025, identified R39's current nursing orders and treatments being completed along with staff initials to demonstrate their	F 605			

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F 605	Continued From page 7 administration and/or refusal. This included a weekly skin assessment and a single flush to the ears for wax build-up; however, both the medication and treatment flowsheet(s) lacked evidence of what, if any, potential side effects with psychotropic medication were being monitored despite R39 having ongoing complaints of feeling tired. Further, R39's medical record was reviewed and lacked evidence of ongoing psychotropic medication side effect monitoring being completed to determine what, if any, effects had been identified or warranted ongoing monitoring despite R39 having potential effects (i.e., sleepiness). When interviewed on 5/21/25 at 8:39 a.m., RN-A verified they worked with R39, and explained when a psychotropic medication was adjusted then a short-lived order was placed on the "MAR or TAR" to monitor them for a response to the medication adjustment. However, this was more for behaviors and if they increased or decreased, and not for side effects of the medication. RN-A stated they were unsure when this was last completed for R39 and expressed it was just done if it showed on the MAR or TAR to be done and not on an ongoing basis. RN-A added, "I couldn't tell you when I last charted it." RN-A stated they were unsure who or where ongoing side effect monitoring would be documented in the medical record. RN-A stated R39 complained "everyday" about being tired but R39 wanted the medications to continue as she'd rather be more tired without anxiety. On 5/21/25 at 10:52 a.m., the director of nursing (DON) was interviewed. DON verified they had reviewed R39's medical record and explained when a medication was adjusted then a	F 605			

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F 605	Continued From page 8 short-lived order was placed to monitor the resident for their mood and behaviors. DON stated side effect monitoring was done "by exception" if noticed only. DON verified they were unable to provide documentation to show ongoing side effect monitoring but acknowledged the importance of monitoring for side effects to help ensure they don't worsen adding, "We want to prevent those things." R56 R56's annual Minimum Data Set (MDS) assessment, dated 4/25/25, indicated R56 had intact cognition with no hallucinations or delusions and no behavioral symptoms including physical or verbal behavioral symptoms directed at others, or behavioral symptoms not directed toward others. Further, it indicated R56 received an antipsychotic and antidepressant medication. R56's May 2025 Medication and Treatment Administration Record (MAR/TAR), included the following orders: -"aripiprazole (antipsychotic medication used to treat mental/mood disorder) 2 milligram (mg) by mouth daily AM indicate for Use: other: severe episode of recurrent major depressive disorder, with psychotic features" with a start date of 2/17/25. Medication was noted as administered 5/1/25 through 5/21/25. -Celexa (antidepressant medication used to treat depression) 20 mg by mouth daily Am indication for use: depression" with a start date of 5/21/24. Medication was noted as administered 5/1/25 through 5/21/25.			F 605			

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F 605	Continued From page 9 The document lacked evidence of side effect monitoring. R56's ADL Care plan, indicated the care plan was last updated on 4/14/25 and included the following information: - "Please complete pivot transfer recliner to w/c (wheelchair) and w/c to recliner only. He will require A1 (assist 1) w/2ww (with 2 wheeled walker). Use EZ stand (mechanical lift) for all other transfers)." ADL Care Plan lacks evidence of side effect monitoring. R56's Care Plan, included the following information: -transferring: 2 assist with use of EZ stand. 2/11/25 foal: sand pivot w/c to recliner. Please use 2 ww for pivot only for power w/c to and from recliner. EZ stand for all other transfers. -"please administer my scheduled Celexa ordered, observe my for potential s/s of increased depression including social withdrawal, changes in my usual eating/sleep pattern." R56's care plan lacked indication R56 was prescribed an antipsychotic medication, possible side effects of antipsychotic medications, and monitoring of side effects of antipsychotic medication (i.e., tardive dyskinesia or orthostatic hypotension). Further, R56's care plan lacked identification of side effects of antidepressant medication and monitoring for side effects of antidepressant medication. R56's vital sign logs, for 2/25/25 through 5/20/25 were reviewed. The document lacked evidence of orthostatic blood pressures being completed. R56's progress notes, for 2/25/25 through			F 605			

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F 605	Continued From page 10 5/202/25 were reviewed. Progress notes lacked evidence of side effect monitoring. R56's Behavior Monitoring/Psychotropic Medication Use assessment, dated 10/24/24, reviewed. The document identified R56 transfers with 2 assist and an EZ stand, and assessment being completed secondary to new medication order of Abilify (aripiprazole). The document lacked evidence of side effects to monitor for either antipsychotic or antidepressant medications. R56's Behavior Monitoring/Psychotropic Medication Use assessment, dated 4/24/25, reviewed. The document identified R56 had orders for aripiprazole and Celexa which was administered to R56. The document lacked evidence of side effects to monitor for either medication. During an interview on 5/19/25 at 3:21p.m., R56 was observed sitting in his room in his recliner. R56 was soft spoken but engaged in conversation. On 5/20/25 at 3:41 p.m., R56 was observed in his recliner in his room. R56 stated he was getting ready to take a nap. During an interview on 5/21/25 at 10:52 a.m., registered nurse (RN)-A stated when a resident starts on a psychotropic medication, side effects are monitored and charted as a progress note. RN-A was uncertain about ongoing side effect monitoring. RN-A stated when orthostatic blood pressures are to be checked there would be an order and it would be found on the MAR/TAR. RN-A reviewed R56's orders and MAR/TAR and			F 605			

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F 605	Continued From page 11 verified there was no current order for obtaining orthostatic blood pressures. RN-A verified R56 had not had an orthostatic completed and documented since at least February 2025. RN-A stated R56 transfers with an EZ stand or a pivot transfer with staff assistance when going from his wheelchair to recliner. RN-A stated checking orthostatic blood pressures are important to ensure there isn't a drop in blood pressure putting residents at greater risk for falls and injuries. During an interview on 5/21/25 at 11:07 a.m., director of nursing (DON) stated documentation was completed more by exception meaning if something was wrong then it would be documented on. When asked specifically about side effect monitoring for psychotropic medications, DON stated "don't technically monitor for side effects" as we chart by exception. During a follow up interview on 5/21/25 at 11:46 a.m., DON stated he was unsure if it was recommended that orthostatic blood pressures be completed on residents who are on antipsychotic medications. DON stated the facility does orthostatic blood pressures after a resident falls or if there is a specific doctor order to complete them. DON stated orthostatic blood pressures are not being completed on residents who are taking antipsychotic medications. On 5/21/25 at 12:06 p.m., surveyor left consulting pharmacist (pharm)-A a voicemail message requesting a call back. During a phone interview on 5/22/25 at 9:56 a.m., pharm-A verified she was the consulting pharmacist for the facility. Pharm-A stated she was not sure if orthostatic blood pressures should	F 605			

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F 605	Continued From page 12 be monitored when a resident was taking an antipsychotic medication. Pharm-A stated that the facility does a DISCUS (a dyskinesia identification system condensed user scale - monitors for tardive dyskinesia) every 6 months, when the medication is started to get a baseline and when the medication is discontinued. Pharm-A stated she has "seen very few cases of TD (tardive dyskinesia), typically when someone who previously had TD," and with the new antipsychotics we see it less than with the older antipsychotics. R9's quarterly Minimum Data Set (MDS) assessment dated 5/2/25, identified R9 had intact cognition and demonstrated no delusional thinking during the review period. Further, the MDS outlined R9 consumed antidepressant medications. R9's Medical Plan of Care dated 12/18/24, identified R9's medications and nursing orders with their corresponding start date(s). This identified R9 as being over 65 years old and having active orders for multiple psychotropic medications including: -Trazodone (antidepressant, commonly used sleep aid) 150 mg daily at bedtime -Prozac (antidepressant) 30 mg daily in the morning R9's Care Plan, dated 12/18/24, identified R9 was unable to walk at this time due to onset of severe back pain. A section labeled "Sleep" identified R9 had trouble sleeping and would require Trazodone every night; notifying provider if R9 had trouble sleeping or irregular sleep pattern. A section labeled "Medication" identified R9 received Prozac for depression; monitor for effectiveness and side effects of these			F 605			

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F 605	Continued From page 13 medications, report any significant changes in mood/behavior. A section labeled "Behaviors" identified R9 was sometimes noncompliant with medications and treatments; remind R9 the provider has ordered the medications and treatments and the benefits these provide. However, none of these care plans specified, if any, potential medication side effects were identified for R9 or being monitored despite R9 consuming multiple psychotropic medications. During interview on 5/20/25 at 10:39 a.m., nursing assistant (NA)-E stated, she isn't sure what side effects they would monitor for someone on a sleep aid, like Trazodone, because if it worked then the resident would be asleep. If the resident was still awake after taking the sleep aid then she would let the nurse know. NA-E stated, if a resident has a specific side effect to watch for, there would be an order and an area to chart in the treatment administration record (TAR). NA-E stated, she doesn't think any residents on the unit has side effects to monitor or chart on. During interview on 5/20/25 at 10:46 a.m., licensed practical nurse (LPN)-A stated, staff monitor side effects right after the resident starts a new psychotropic medication; usually 1-2 weeks are monitored. LPN-A stated, the side effects while a resident is taking a psychotropic medication include increase sleepiness, dizziness, agitation, problems with gait (walking), suicidal, or uncontrolled movements. LPN-A stated, most of the residents have been on these types of medications for a long time so they aren't being monitored for side effects. During interview on 5/21/25 at 10:52 a.m., director of nursing (DON) stated documentation			F 605			

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F 605	Continued From page 14 was completed more by exception, meaning if something was wrong then it would be documented on. DON stated, "don't technically monitor for side effects" as we chart by exception. A facility-provided Psychotropic Medication policy, dated 2/2024, identified residents would receive psychotropic medications when needed to treat specific conditions or symptoms. The policy continued, "Nursing employees shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the provider [listed]," however, the policy lacked how the campus would monitor for side effects with non-antipsychotic psychotropics (i.e., antidepressants, hypnotics); nor direction on where this monitoring would be documented within the medical record. PRN MEDICATION: R31's quarterly Minimum Data Set (MDS) assessment dated 5/16/25, identified R31 had significant cognitive impairment. Diagnoses included progressive neurological condition, dementia, anxiety and depression. Medications received included an antipsychotic, antianxiety, antidepressant and opioid. R31's Care Area Assessment (CAA) dated 12/2/24 included psychotropic drug use. The CAA triggered related to resident having received scheduled antipsychotic medication, antianxiety and antidepressant medications. R31 received Seroquel (antipsychotic medication) twice a day and had previously received three times a day. R31 also received Buspar (used to treat anxiety) three times a day and sertraline (used to treat depression, panic disorders, and anxiety) every	F 605			

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F 605	Continued From page 15 day. R31 also had an as needed lorazepam (used to treat anxiety and insomnia) and Seroquel available which were not used during the look back period. Administer as needed lorazepam when other interventions have been ineffective in controlling symptoms of anxiety. R31's Medical Plan of Care, last signed 5/7/25 included lorazepam 0.5 mg tablet by mouth every 4 hours as needed for anxiety. *No scheduled end date due to hospice*. R31's Medical Plan of Care was also signed on 3/26/25, 1/15/25, 10/30/24, and 7/11/24. The orders did not include a rationale to extend the medication. R31'S Medication Administration Report (MAR) for 11/21/24 through 5/21/25 were reviewed. R31 received the lorazepam medication on 11/22/24, 12/7/24, 12/11/24, 12/19/24, 12/22/24, 12/27/24, 12/29/24, 12/30/24, 1/7/25, 1/9/25, 1/13/25, 1/17/25, 1/25/25, 2/13/25, 2/15/25, 2/16/25, 2/17/25, 2/21 through 3/7/25, 3/10 through 3/12/25, 3/22/25, 4/15/25, and 5/15/25. R31's plan of care dated, 4/25/25 included self care deficit related to dementia and weakness. Behaviors included a long history of anxiety and depression and receives medications for these. Will yell out "help me" which disrupts the living environment. R31 is calmer when wife is with him, or 1:1 staff. As needed medications have been helpful when other interventions were not effective. Reorient and reassure R31 as needed, approach in a calm manner, introduce self each time, explain what assistance is being provided, encourage participation in diversional activities, provide 1:1 as able and use as needed medications when available. Notify hospice, nurse manager or physician if frequency of as	F 605			

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F 605	Continued From page 16 needed medication is increased and or anxiety increases. An interview and observation on 5/19/25 at 2:58 p.m., R31's family member (FM)-A indicated R31 gets sleepy after use of the as needed medication or change in his scheduled medication and has addressed this with the facility. FM-A stated things have gotten better over the past few months. R31 stated it is going okay here at the facility and is thankful FM-A is here frequently. R31 was sitting in his recliner and was alert and answering questions, but frequently looked to FM-A to answer questions. An interview 5/21/25 at 8:06 a.m., pharmacist (Pharm-A) stated all psychotropic medications required to have an end date and need to be reviewed by the provider prior to that end date even if they are a hospice resident. Pharm-A stated for as needed use for hospice they can go out six months as long as a rationale is included. Pharm-A stated she must have missed that on R31. An interview 5/21/25 at 8:30 a.m., registered nurse, hospice case manager (RN)-H, stated she is not aware of a requirement of end date of 14 days or need for rationale if extended longer for as needed psychotropic medications. An interview 5/21/25 at 9:23 a.m., registered nurse (RN)-B, stated generally as needed psychotropic medications require a renewal and face to face every 14 days. However, hospice has told the facility that isn't the case for hospice residents. RN-B stated the facility added the statement "**No scheduled end date due to hospice*" behind the order so staff are aware it	F 605			

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F 605	Continued From page 17 isn't required. An interview 5/21/25 at 10:07 a.m., the director of nursing (DON) confirmed lorazepam is required to be renewed with face to face every 14 days even if residents are on hospice. Facility policy was requested for Psychotropic Medications use. A Consultant Pharmacist policy dated 12/17/24 was received and included the purpose is to provide pharmaceutical services in an accurate and safe manner with the collaboration between the pharmacy consultant facility leadership, facility staff, practitioners and the medical director to meet the individualized needs of the residents in this facility. The pharmacy consultant will complete at least a monthly medication regimen review for each resident in the facility and will meet all other responsibilities required of a qualified consultant pharmacist as set forth in any federal or state law, statues or regulations as enacted or as may be enacted or amended.	F 605			
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review the facility failed to identify and document	F 699	R59's care plan revised to include diagnosis of PTSD, known triggers for		8/13/25

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F 699	Continued From page 18 the trauma-related history, post-traumatic stress disorder (PTSD), known triggers and lacked a system or process for completing trauma assessments for 1 of 1 residents (R59) with a known history of PTSD. Findings include: R59's quarterly Minimum Data Set (MDS) assessment dated 5/16/25, indicated intact cognition with no behaviors. Diagnosis included post traumatic stress disorder and anxiety. R59 required partial to moderate assist for transfers, ambulation, toileting and personal hygiene. R59 was taking an antidepressant medication. R59's care plan dated 9/12/24, included a problem of self-care deficit related to activity intolerance, due to medical diagnoses. Resident history included he served in Vietnam. Behaviors included R59 may refuse cares at times and also forget to ask for assistance when needed. R59 may have crying episodes at times and doesn't like confined small spaces. A Behavioral Health Note dated 5/31/24 included a past psychiatric history of PTSD and readily engaged in testimony as to prior traumatic experiences. R59 has a substantial history of prior military traumas and personal losses which have been suppressed and managed through years of avoidance and distraction. R59's document review failed to include a trauma assessment or evaluation of R59's PTSD. R59's behavioral care plan failed to identify triggers or interventions related to managing R59's PTSD. On 5/19/25 at 6:05 p.m., R59 stated he served in			F 699	PTSD and interventions identified by 6/30/2025. Trauma-informed care screening and care plan development (if applicable) to be completed on all new admissions within 7 days by 7/15/2025. Social services team or designee to complete screening as part of social history admission assessment. For current residents, the facility team (licensed social worker or designee) will complete the trauma-informed care screening during the residents' next scheduled annual or quarterly MDS or by August 21, 2025 (for those residents whose MDS ARD is past this date). Trauma informed care policy to be developed by July 31, 2025 and presented at August 13th, 2025 QAPI meeting. Administrator (or designee) will conduct random audits of a minimum of 3 new resident admissions per month (July, August, September 2025) to verify Trauma Informed Care screening tool is complete and care plan developed (if indicated). Findings to be shared at monthly QAPI meetings (July-Sept 2025). Deficient practices identified during the MDH survey reviewed and preliminary plan of correction were discussed and reviewed with IDT at June 11th, 2025 QAPI meeting.		

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F 699	Continued From page 19 the military and in Vietnam. R59 stated the Veterans Administration (VA) has treated him well for the most part. R59 stated he likes to be outside where he gets fresh air and when confined inside he feels sometimes like he can't get his breath. R59 would like staff to take him on walks outside more or at least just walk him outside of his room but it doesn't always happen and he feels like staff don't always listen to him. R59 was seated in his wheelchair in his room with oxygen on per nasal cannula. A walker was present. On observation 5/20/25 at 1:10 p.m., R59 was observed seated in a wheelchair in the sun room playing checkers with another resident. R59 did not have his oxygen on. On observation and interview 5/20/25 at 3:30 p.m., R59 was accompanied by nursing assistant, ambulating in the hallway with his walker with his oxygen on per nasal cannula. R59 smiled and said "it feels good to be walking and be out of my room". On interview 5/20/25 at 1:37 p.m., social services (SS)-A stated she was aware R59 had a PTSD diagnosis but the facility only does mood assessments and a PTSD assessment would be done by a doctor or psychiatrist. SS-A stated they do not have a screening process in place for admissions for PTSD at this time. SS-A stated if someone has issues with PTSD we would do a behavioral care plan and do 1:1's with the resident. On 5/20/25 at 1:48 p.m., registered nurse (RN)-B stated nurses do not do a PTSD screen or assessment on admission. RN-B confirmed the			F 699			

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F 699	Continued From page 20 care plan did not have any triggers listed, but she is aware he likes to be outdoors and doesn't like being stuck in his room with 4 walls. RN-B added R59 enjoys talking to other veterans, but only will talk about his PTSD when he wants to but not about actual events that happened. RN-B added R59 can walk on his own without staff present and frequently leaves his room on his own. On interview 5/20/25 at 2:43 p.m., RN-D stated he was not aware of R59's PTSD diagnosis and is not aware of triggers or interventions related to PTSD for R59. RN-D indicated generally he would look in the mood or behavioral care plan for triggers and interventions. On interview 5/20/25 at 3:38 p.m., nursing assistant (NA)-C and NA-D stated they were not aware of R59's PTSD. NA-C and NA-D stated they rely on other staff to let them know if they are having behaviors or not or look at the updated care plan in the book on the unit but that only covers activities of daily living like how many people to transfer, bath, etc.. On interview 5/21/25 at 9:38 a.m., RN-B stated the facility does not have a policy and procedure related to trauma informed care and provided Behavioral Assessments, Intervention and Monitoring policy and Abuse, Neglect, Mistreatment and Misappropriate of Resident Property policy and procedure. On 5/21/25 at 10:01 a.m., the director of nursing confirmed R59 did not have a PTSD assessment or plan of care and stated he was not aware of the trauma informed care regulations. A Behavioral Assessments, Intervention and			F 699			

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F 699	Continued From page 21 Monitoring policy dated 12/12/24 included: - Upon admission, residents who display or are diagnosed with a mental disorder or psychosocial adjustment difficulty, or who have a history of trauma and or post-traumatic stress disorder will have referrals made for on-site or off-site psychiatric/psychological services. - Specific, individualized interventions will be put into place to aide in the behavior management that included non-pharmacological modalities. - The inter-disciplinary team will meet to review and discuss specific resident behaviors, appropriateness and effectiveness of interventions, current medications, psychiatric service recommendations. Resident behavior health needs will be addressed on the resident's person centered plan of care.	F 699			
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 700			7/31/25

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F 700	Continued From page 22 §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure alternatives (i.e., small grab bar, positioning devices) were offered, attempted and recorded in the medical record prior to the use of bilateral one-half (1/2) side rails for 4 of 4 residents (R122, R45, R56, R222) observed to have side rails attached to their bed. Findings include: R122 R122's admission Minimum Data Set (MDS) assessment dated 5/16/25, identified R122 had intact cognition and demonstrated no delusional thinking during the review period. Further, the MDS included a section labeled, "Section P - Restraints," which identified R122 used no bed rails. R122's Restraint Use Assessment, dated 5/9/25 and located with her registered nurse (RN) charting, identified R122 as admitting from the emergency department (ED) and having a history of heart failure, obesity, and diabetes. The evaluation outlined, "Upon assessment of the resident, there is no current need for any restraints at this time as she is content with her admittance to the facility." The note concluded, "... continue to monitor resident for any changes ..."			F 700	At time of plan of correction submission, facility does not have inventory of alternative repositioning devices (such as transfer poles, bed ladders or halo safety rails) for transfer aids or bed mobility for residents identified as needing them to promote improved bed mobility and getting in/out of bed. The facility is identifying a budget plan to include siderail alternatives that are currently in use, such as halo safety rails and bed ladders, in collaboration with the therapy team by 7/31/2025. Inquiry to manufacturer of current hospital bed model for acceptable products completed by 6/20/2025. Facility does have bumpers, lippy mattresses and floor mats as alternative measures than siderails for reasons other than bed mobility and transfer assistance. Updated safety assessment for siderails and consent forms completed for R122, R45 and R56 by 6/30/2025. R222 passed away 5/25/25. Facility to identify other affected residents through environment of care rounds and chart review to determine what residents currently have siderails for bed mobility or assisting with transfers by 7/15/2025. The facility will verify that affected residents have a current safety assessment for siderails and fully complete consent form		

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F 700	Continued From page 23 However, on 5/19/25 at 2:51 p.m., R122 was observed lying in bed while in her room. R122's bed had bilateral, chrome-colored metallic 1/2 side rails on both sides of the bed which attached to the bed frame using a single bracket on the bottom. The rail attached to the open side of the bed (side to rise/enter) was mildly loose when touched and the rail moved several inches side-to-side despite being attached to the bed. R122 stated she admitted to the care center the week prior from the hospital campus due to needing a ceiling lift for transfers. R122 stated staff had come into her room after she admitted and "made me sign something" about using the side rails, however, had never asked her about wanting them or not; nor any alternative devices (i.e., smaller grab bar) prior to installing them. R122 stated, rather, staff just showed up with them in the room and said 'can we install these?' to which R122 responded, "Sure." R122 stated she used the rails to help with bed mobility, and she denied concerns or injury from these, thus far. R122's Consent for Use of Bed Rails/Assist Devices, dated 5/9/25, identified a written marking next to an option which read, "Half (1/2) Rail," along with sections to outline potential benefits and risks with the use of the device. The form identified the rails were recommended due to two options listed as, "Resident Choice/Security," and, "Bed Safety." R122 signed the consent on 5/9/25, however, the spacing to have a staff member sign it was left blank. However, again, the form lacked evidence of what, if any, alternatives to a 1/2 side rail were considered, offered or discussed as a potential alternative to R122 prior to their installation.			F 700	by 7/31/2025. Policy "Proper Use of Side Rails/Assistive Devices" reviewed and revised, if applicable, and presented at QAPI meeting by 7/15/2025. Staff education to be provided on alternative measures to consider other than siderails during June 2025 and July 2025 nursing team meetings. Director of Nursing (or designee) will conduct random chart and room audits on five residents per month for three months (July/August/September 2025) to verify that residents with siderails have had alternatives attempted and documented prior to implementing traditional ½ side rails. Deficient practices identified during the MDH survey reviewed and preliminary plan of correction were discussed and reviewed with IDT at June 11th, 2025 QAPI meeting.		

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F 700	Continued From page 24 R122's corresponding Resident Assessment, dated 5/9/25, identified a section labeled, "Side Rails/Assistive Devices Assessment Required," with a checkmark placed to demonstrate an affirmative (i.e., yes) response. The section included four questions to be answered by staff with a checkmark placed next to either a, "Yes," or, "No," response. These questions were all marked to affirm R122 was able to demonstrate safe use of the rails, able to understanding the potential risks of them, able to use her call light appropriately, and the use of the rails would enhance the resident' mobility in bed or with transfers. However, the completed evaluation lacked evidence of what, if any, alternatives to a 1/2 side rail were considered, offered or attempted prior to their installation. Further, R122's ADL care plan, dated 5/14/25, identified R122 needed assistance of two with a mechanical lift for transfers. The care plan continued and identified R122 was independent with side to side bed mobility with only assist of one as needed (i.e., PRN). Further, the plan outlined a section labeled, "Siderails," which indicated, "1/2 bilateral." When interviewed on 5/20/25 at 10:38 a.m., nursing assistant (NA)-A stated they had worked with R122 multiple times prior, and described her as pretty independent with most cares. NA-A explained R122 used a mechanical lift for transfers and, with bed mobility, expressed the staff helping her "generally [had] to move her" while in bed as R122 seemed to struggle in boosting herself up. NA-A verified R122 used bilateral side rails, and stated she had used them since admission adding, "As far as I know." NA-A stated multiple residents used them and expressed the rails were "more kept with the bed,			F 700			

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F 700	Continued From page 25 not with the person" from their understanding of them. NA-A stated they had never seen other devices, such as a trapeze or smaller grab bar, used on R122's bed since she admitted and, again, reiterated it was "almost always" just the bilateral side rails used on resident' beds. R122's medical record was reviewed and lacked evidence of what, if any, alternatives to a 1/2 side rail had ever been presented, evaluated, or offered to R122 prior to the installation of bilateral 1/2 side rails. On 5/20/25 at 2:28 p.m., the director of nursing (DON) was interviewed. DON verified R122 had 1/2 bilateral side rails attached to her bed and expressed they were used for positioning and not as a restraint. DON explained the nurses, upon admission, evaluate the need for them through their assessment process and obtain a physician order for them before their installed. DON stated he was unable to "speak to the options" which may have been presented to R122 instead of a side rail as he didn't complete the assessment, however, felt there were no other options (i.e., smaller grab bar, trapeze) even to use. When questioned on what, if any, alternatives to the side rails were ever offered to R122 either upon admission or since, DON responded, "That I cannot speak to." DON stated they would discuss the matter with other nurses and obtain more information. During follow-up interview, at 3:32 p.m., DON verified they were unable to locate evidence in the medical record on what, if any, alternatives had been offered or considered prior to the side rails being installed. DON stated they reviewed the facility' policy on side rails and it did direct to check for alternatives prior, such as a trapeze, before the rails are installed. DON stated	F 700			

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F 700	Continued From page 26 they were unsure what other alternatives the center had available to install, but acknowledged smaller bars or options may well work for residents. When interviewed on 5/20/25 at 3:45 p.m., the facilities manager (FMR) stated the center used two different types of bed, and maintenance was repeatedly taking rails on and off of them as residents would admit or discharge from the campus. FMR stated an assessment of the rail safety or any alternative would be completed by nursing adding their department (maintenance) just assumed that was done prior to them requesting the rails installed. FMR stated nobody from the care center had ever asked them about what, if any, alternatives were available adding, "We were never asked to look into that." R45 R45's significant Minimum Data Set (MDS) assessment dated 3/7/25, indicated R45 admitted to the facility on 9/11/25, had intact cognition and independent with transfers. The MDS indicated in section, "P0100. Physical Restraints," that R45 had bed rails that were not used as restraints. R45's Consent for Use of Bed Rails/Assist Devices dated and signed by R45 on 9/11/24. The document listed benefits and potential negative outcomes of side rails. The document lacked any documentation or evidence of alternative methods/products attempted prior to the use of bed rails. Furthermore, the document had a section titled "RECOMMENDATIONS: Based on physical and cognitive assessment,	F 700			

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F 700	Continued From page 27 indications for the use of side rails or assistive device are: resident choice/security, mobility bed safety, other" which have boxes next to them to indicate. This area of the document was left blank. Furthermore, the document had a section "TYPE OF RAIL/ASSIST DEVICE" with small box next to the option to be marked to indicate what type of device to be used. The options included: quarter (1/4) rail, half (1/2) rail, Full rail, assistive device, and other. This area was left blank with no options marked. The consent for use of bed rails/assist device was not completed in full. R45's Resident Assessment dated 9/11/24, indicated R45 was able to demonstrate safe use of the side rails/assistive device, verbalized understanding of potential risks, demonstrated the ability to use the call light appropriately for assistance and would use the side rails to enhance bed mobility or with transfers. A physician order dated 9/11/24 included an order for ½ (half) bilateral siderails. During an interview and observation on 5/19/25 at 3:35 p.m., R45 stated he has had bed rails since he moved into the facility last September which were observed to be on his bed. R45's bed had bilateral, chrome-colored metallic 1/2 side rails on both sides of the bed which attached to the bed frame using a single bracket on the bottom. The rail attached to the open side of the bed (side to rise/enter) was mildly loose when touched and the rail moved several inches side-to-side despite being attached to the bed. During a follow up interview on 5/20/25 at 10:30 a.m., R45 stated he used the bed rails to prop himself up at night to use the urinal. R45 stated the bed rails had always been on the bed and did not know about			F 700			

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F 700	Continued From page 28 any alternatives to bed rails. R45 stated the bed rails had always been a little loose and denied any concerns with this. R45 denied any injuries related to using bed rails at this time. During an interview on 5/20/25 at 2:33 p.m., director of nursing (DON) stated he cannot speak to how often assessments are completed for the use of bed rails but believed it would be upon admission and with a significant change or change of condition. DON verified R45's Consent for Use of Bed Rails/Assist Devices was not completed as the section for indication for use and type of rail was left blank and stated it should have been filled out completely. During a follow up interview on 5/20/25 at 3:33 p.m., DON verified he was able to review R45's medical chart. DON stated R45 did not have any alternatives attempted prior to installation of bed rails. R56 R56's annual MDS dated 4/25/25, indicated R56 had intact cognition and required maximal staff assistance with bed mobility with an admission date of 5/21/24. The MDS indicated in section, "P0100. Physical Restraints," that R56 had bed rails that were not used as restraints. R56's Consent for Use of Bed Rails/Assist Devices dated 5/21/24. The document listed benefits and potential negative outcomes of side rails. The document lacked any documentation or evidence of alternative methods/products attempted prior to the use of bed rails. A physician order dated 5/21/24 included an order	F 700			

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F 700	Continued From page 29 for ½ (half) side rails to bed for mobility. During an interview and observation on 5/20/25 at 3:41p.m., R56 stated he has had bed rails since moving to the facility. R56 stated he uses them to get out of bed. R56 stated they have "always been a little wiggly." R56 stated they have never been tightened since being attached to the bed nor had they become unattached when using them. R56 stated he has never tried or been offered any other devices to help with mobility beside the bedrails. R56's bed had bilateral, chrome-colored metallic 1/2 side rails on both sides of the bed which attached to the bed frame using a single bracket on the bottom. The rail attached to the open side of the bed (side to rise/enter) was mildly loose when touched and the rail moved several inches side-to-side despite being attached to the bed. During an interview on 5/20/25 at 3:33 p.m., DON verified he reviewed R56 medical chart and stated R56 did not have any alternative attempted prior to the installation of the bed rails. R222 R222's admission Minimum Data Set (MDS) assessment, dated 5/15/25, indicated R222 had moderate cognitive impairment with no behaviors. R222 had no impairment to upper or lower body extremities, was set up assist for eating and oral cares, moderate assist for upper body and showering, and dependent on staff for lower body cares. R222 was independent with repositioning side to side, moderate assist with changing to and from lying to sitting, and dependent on staff for standing and transfers. The MDS also indicated R222 had no bedrails or alarms. R222 was enrolled in hospice care.			F 700			

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F 700	Continued From page 30 R222's provider orders included morphine as needed for pain, lorazepam as needed for pain, anxiety, sleeplessness, shortness of breath, oxygen 3 liters per minute, and venlafaxine daily for depression. R222's admission careplan indicated R222 require 1 assist for activities of daily living, had no behaviors. During observation on 5/19/25 at 4:10 p.m., R222's bed had bilateral chrome half upper side rails attached to the frame of the bed at one attachment point. The grab bar was loose. During interview on 5/19/25 at 10:50 a.m., R222 stated she uses the side rails to reposition in bed and help her sit up. R222's side rail assessment dated 5/9/25 was marked "N/A". R222's "restraint use assessment" progress noted dated 5/9/25 indicated "No restraints recommended. Resident declines wanting to use side rails at this time. Will re-evaluate as needed." During interview on 5/20/25 at 12:58 p.m., nursing assistant (NA)-A stated R222 can reposition self and does not use side rail often. NA-A stated the beds come with the side rails. They can be detached upon request however are kept for "safety's sake". During interview on 45/20/25 at 1:20 p.m., registered nurse (RN)-E stated R222 is able to make some position changes independently	F 700			

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F 700	Continued From page 31 however does need assistance to sit up. R222 does use the side rails to help with positioning. RN-E stated resident's require a provider order for side rails which should be indicated in the medical plan of care. RN-E confirmed R222 does not have an order for side rails. RN-E then stated, "you know what, it is careplanned." RN-E confirmed R222's careplan indicated "no side rails". RN-E stated physical therapy usually assesses for the need for side rails upon admission. During interview on 5/20/25 at 1:29 RN-F stated R222's family stated they wanted R222 to have the side rails, however, they could not find a consent for the side rails in the hospice book or R222's hard chart. Facility policy, Proper Use of Side Rails/Assistive Devices, dated 12/2023, identified a purpose of ensuring the safe use of side rails and assistance devices. The policy outlined these would only be used to treat a medical symptom or to assist with mobility and transfers. The policy outlined, "Less restrictive interventions that will be incorporated in care planning include ... Providing a trapeze to increase bed mobility ..." Further, the policy outlined, "Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails/assist devices."	F 700			
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure	F 726			7/31/25

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F 726	Continued From page 32 resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure direct-care staff were trained and competent in the daily use of resident' medical equipment to ensure safety and reduce the risk of complication (i.e., device failure) for 1 of 1 resident (R53) who used a bed-side continuous positive airway pressure (i.e., CPAP) machine. Findings include:			F 726	The manufacturer's care guide obtained for R53's specific CPAP and placed in resident hard chart for reference by 6/30/2025. R53 Treatment Administration Record (TAR) updated to provide additional information for R53's CPAP by 6/30/2025. Review of basic use and care of CPAP, troubleshooting and resources provided to		

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F 726	Continued From page 33 R53's admission Minimum Data Set (MDS), dated 3/31/25, identified R53 had moderate cognitive impairment but demonstrated no delusional thinking during the review period. The MDS outlined R53 had several medical diagnoses including atrial fibrillation, chronic kidney disease (CKD); and used a non-invasive mechanical ventilator while a resident at the care center. R53's Insomnia Assessment, dated 3/21/25, was recorded in her progress notes. This identified R53 denied any concerns with sleeping and used a CPAP device. On 5/19/25 at 3:05 p.m., R53 was observed seated in a recliner chair while in her room. R53's bed was positioned along the window and adjacent was a small bedside dresser which had a black-colored Resmed Airsense 10 CPAP sitting on top with an attached mask hooked onto the wall. R53 stated their significant other who visited the campus several times a week managed the device for her mostly and did the cleaning and maintenance of it for her. R53 stated the settings for the machine were pre-programmed by the significant other and staff usually just helped her turn it on to use. R53 stated the machine did, at times, have an issue or stop working with an alarm adding when that happens, she would ask staff for help with it. R53 stated she was unsure how knowledgeable staff were about the device though as some staff seemed to not know how to use it. R53 stated she started questioning staff now if they know how to use it before they touch it adding aloud, "I ask them." When interviewed on 5/20/25 at 12:44 p.m.,			F 726	licensed team members responsible for managing and maintaining during the June and July 2025 nursing team meetings (complete by 7/31/2025). Policy "CPAP (Continuous Positive Airway Pressure), Use of" reviewed and revised, as applicable by 7/15/2025. Chart review completed to identify other residents that currently use CPAP by 6/30/2025. Manufacturer's guide obtained and placed in each resident hard chart for reference by 7/15/2025. Identified residents will have treatment administration record (TAR) reviewed and updated (if needed) with specific information on the CPAP in use. Director of Nursing (or designee) to review current inventory of specialty medical equipment in use (CPAPs, Wound Vac, Suction, etc.) and determine if additional inservicing or education is needed by 7/15/2025 and proceed accordingly. Deficient practices identified during the MDH survey reviewed and preliminary plan of correction were discussed and reviewed with IDT on June 11th, 2025 QAPI meeting.		

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F 726	Continued From page 34 nursing assistant (NA)-B stated R53 was often not accepting of help with cares and "likes to do her own thing." NA-B stated R53 used a CPAP at night adding she had done for since admission to the care center. NA-B stated the NA staff do nothing with it, however, rather the device was maintained by the nurses adding aloud, "The nurses are supposed to manage that." R53's Treatments flowsheet, dated 5/13/25 to 5/20/25, identified a nursing order which read, " ... Cleanse CPAP daily in the AM and let air dry [am shift]," with a listed start date, "03/21/2025." The order was signed off as completed each day during the period with staff initials. The provided flowsheet lacked any further information about the CPAP including settings the device should be at or any troubleshooting information about potential malfunctions or alarms which could activate. On 5/20/25 at 1:08 p.m., registered nurse (RN)-A was interviewed, and verified they were assigned care for R53. RN-A explained they had worked with R53 multiple times prior and described her as needing more help than she'd often allow for cares. RN-A verified R53 used a CPAP and nurses cleaned it, however, R53 would often re-assemble it before it was dry on her own. RN-A stated the settings were programmed into the device and the "second shift" was more responsible for the device, however, at times, they had to deal with the device adding a situation had happened just last week where they couldn't get the device to turn off. RN-A stated they had to call R53's significant other at home to triage and resolve the issue over the telephone adding they were concerned about "screwing something up" on the device. RN-A stated each CPAP machine	F 726			

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F 726	Continued From page 35 was a little different and staff, at times, would "almost have to YouTube it" to learn how to use it. RN-A stated the facility had not provided them or any nurses with training on the CPAP device; nor was their a manual kept around about it adding aloud, "I don't recall any." When interviewed on 5/20/25 at 1:40 p.m., the director of nursing (DON) stated there were several models of CPAP but all seemed to work on the same "basic understanding" and operation with function. When questioned on how these devices were taught to the direct care staff, then DON explained they used a model of a staff member learning the device, then teaching everyone else; however, DON stated they were unsure who was responsible to facilitate this model of teaching adding, "That I can't speak to." The DON stated, "I would hope they have some critical thinking skills and look it up online." DON stated it would potentially be difficult to teach every model of CPAP but acknowledged the devices were "very important." DON stated most of their completed "in-time training" was done for equipment which had only one model type and voiced an example of their IV pump(s). DON reviewed the NEO (new employee orientation) checklist and verified it lacked training on CPAP device(s) or their use. DON stated they were unsure if a copy of the device' user manual was around the campus or not, however, added printing one off and having it available was likely helpful adding aloud, "I like that idea." DON stated none of the direct care staff had expressed concerns about being unfamiliar with R53's CPAP prior and, if concerns were present, the staff could call a "next level leader" about it, too. DON acknowledged having staff trained and competent in the device was important "just for safety" and	F 726			

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F 726	Continued From page 36 to reduce the risk of infection or complication. A provided CPAP (Continuous Positive Airway Pressure), Use of policy, dated 10/2024, identified general guidelines for the device which included, "Only a qualified and properly trained nurse or respiratory therapist should administer oxygen through a CPAP mask." However, the policy lacked information on what training would be completed by the care center to ensure competency with the device.	F 726			
F 909 SS=C	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop and implement a preventative, regular maintenance program of resident' beds and side rails to ensure safety and reduce the risk of complication (i.e., bed malfunction, entrapment) for 3 of 3 residents (R122, R45, R222) reviewed who used side rails on their bed. However, the lack of a program had potential to affect all 75 residents residing at either campus. Findings include: R122's admission Minimum Data Set (MDS),	F 909	Facility to develop and maintain a preventative bed inspection program for all bed frames, mattresses and bed rails (as applicable) as part of the routine preventative maintenance program by 7/31/2025. All beds that are facility owned (or leased, if applicable), will be included in the preventative bed inspection program. R122 and R45 bed inspection completed by 6/30/2025. Policy, "Bed Inspection" to be developed		7/31/25

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F 909	Continued From page 37 dated 5/16/25, identified R122 had intact cognition and demonstrated no delusional thinking during the review period. Further, the MDS included a section labeled, "Section P - Restraints," which marked R122 as not using a bed rail with dictation, "0 = Not Used." On 5/19/25 at 2:51 p.m., R122 was observed lying in bed while in her room. R122's bed had bilateral, chrome-colored metallic 1/2 side rails on both sides of the bed which attached to the bed frame using a single bracket on the bottom. The rail attached to the open side of the bed (side to rise/enter) was mildly loose when touched and the rail moved several inches side-to-side despite being attached to the bed. R122 stated she admitted to the care center the week prior from the hospital campus due to needing a ceiling lift for transfers. R122 stated staff had come into her room after she admitted and "made me sign something" about using the side rails, however, had never asked her about wanting them or not; nor any alternative devices (i.e., smaller grab bar) prior to installing them. R122 stated, rather, staff just showed up with them in the room and said 'can we install these?' to which R122 responded, "Sure." R122 stated she used the rails to help with bed mobility, and she denied concerns or injury from these, thus far. R45's significant change in status MDS, dated 3/7/25, identified R45 had intact cognition and was independent with transfers and bed mobility. The MDS section labeled, "Section P - Restraints," marked R45 as not using a bed rail with dictation, "0 = not used." On 5/19/25 at 3:35 p.m., R45 was observed in his room. R45 stated he had bed rails attached to his	F 909	and presented at QAPI on 7/9/2025. Facilities Manager (or designee) to verify preventative bed maintenance schedule is developed and maintained by reviewing work order system for completion of bed inspections of at least 5 beds per month x three months (July, August and September 2025.) Deficient practices identified during the MDH survey reviewed and preliminary plan of correction were discussed and reviewed with IDT at June 11th, 2025 QAPI meeting.		

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F 909	Continued From page 38 bed since he moved into the facility last September (2024) and, upon observation, his bed had bilateral, chrome-colored metallic 1/2 side rails which attached to the bed frame using a single bracket on the bottom. The rail attached to the open side of the bed (side to rise/enter) was mildly loose when touched and the rail moved several inches side-to-side despite being attached to the bed. R222's admission Minimum Data Set (MDS) dated 5/15/25 indicated resident had moderate cognitive impairment with no behaviors, and being independent with repositioning side to side, needing moderate assist with changing to and from lying to sitting, and dependent on staff for standing and transfers. The MDS also indicated R222 had no bedrails or alarms. On 5/19/25 at 4:10 p.m., R222's bed was observed which had bilateral, chrome one-half upper side rails attached to the frame of the bed at one attachment point below. The grab bar was loose when touched. On 5/20/25 at 10:38 a.m., nursing assistant (NA)-A was interviewed, and verified R122 along with many other residents used bilateral side rails. NA-A stated the rails were "more kept with the bed, not with the person" from their understanding of them. NA-A stated they had never seen other devices, such as a trapeze or smaller grab bar, used on resident' beds and, again, reiterated it was "almost always" just the bilateral side rails used on resident' beds. SEE F700 FOR ADDITIONAL INFORMATION ON SIDE RAIL USE	F 909			

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F 909	Continued From page 39 When interviewed on 5/20/25 at 3:32 p.m., the director of nursing (DON) stated the campus had multiple types of resident beds and they were unsure what, if any, routine review or maintenance program was being done for them. DON stated if a side rail was found to be loose, then staff could complete a work-order for maintenance to address it. On 5/20/25 at 3:45 p.m., the facilities manager (FMR) was interviewed, and he explained the campus used two types of resident' beds adding there had been discussion on getting some of the more "dated beds" to be phased out in the coming years. FMR explained when a resident discharges the campus, they receive a work-order to remove the side rails from the bed and then, often, get another work-order when a new resident comes in to re-attach the side rails. FMR stated they "just assume" the nursing department has completed their review of the bed or siderail to ensure safety. FMR stated there was no ongoing, routine maintenance program completed for the beds to ensure safety, either with or without the side rail(s) attached, adding aloud, "No, no." FMR stated they had talked about implementing a preventative maintenance program for the beds in the past, however, had "never pursued it." FMR stated the floor staff should be checking the beds to ensure safety adding such was "a responsibility of them [floor staff]." Further, FMR stated they were unsure if the side rails were made by the bed manufacturer and would look into that adding aloud, "That's a great question." On 5/21/25 at 10:33 a.m., a follow-up interview was held with FMR, who explained checking the bed frame and mattress for fitment (i.e., including to reduce the risk of mattress shift and entrapment with the side rail)	F 909			

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F 909	Continued From page 40 was "all on the [direct] staff." FMR stated they would "occasionally" have work-order come through to adjust a mattress but not often. FMR stated they had located the user's manual for the bed type(s) which directed annual maintenance should be completed, however, this was not being done. FMR stated they would start a routine maintenance program for the beds to ensure safety adding aloud, "That's something we're going to have to go forward with." FMR stated there was no specific user's manual able to be located for the side rails and reiterated issues with safety or maintenance would just be addressed as discovered. A facility' provided Excel document, undated, was provided which was labeled, "Work Orders Excel Spreadsheet." This identified all recently completed maintenance items done at either campus. This recorded one issue with a bed control not working, multiple examples of a bed-extender being needed/attached, and one entry which recorded, "Other - has old bed, needs brown siderails attached." The provided document lacked any evidence of ongoing preventative screening or maintenance review to ensure resident' bed safety. On 5/21/25 at 10:46 a.m., a follow-up interview with the DON was held. DON stated there was no set schedule or routine for nursing staff to inspect the resident beds to his knowledge. DON stated beds should likely be inspected on a routine basis though to promote safety and reduce the risk of falls and entrapment. On 5/21/25 at 1:14 p.m. the environmental services director (ESD) was interviewed. ESD explained their staff help with a "monthly bed	F 909			

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F 909	Continued From page 41 wash" on every room and complete the "terminal cleaning" when a resident discharges. ESD explained they inspect the mattress at that time to ensure it's intact and clean, however, this was not tracked or documented. ESD verified they were not checking for preventative maintenance on the beds or areas where potential entrapment could occur adding if a rail was loose, then a work-order would be completed and the maintenance department would address such. ESD provided a document labeled, "Bed Wash," which had each unit listed on a separate page along with initials of staff who completed it. However, the document lacked instructions or directions on what specific items were performed during these monthly washes. A facility' policy on bed maintenance was requested, however, none was received.	F 909			

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NAME OF PROVIDER OR SUPPLIER GUNDERSEN ST ELIZABETH'S CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981			
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/20/2025. At the time of this survey, GUNDERSON ST ELIZABETH'S CARE CENTER - BLDG 02 (GRANT) found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/13/2025

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

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NAME OF PROVIDER OR SUPPLIER GUNDERSEN ST ELIZABETH'S CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981		
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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. GUNDERSON ST ELIZABETH'S CARE CENTER - BLDG 02 (GRANT) is a 2-story building with full basement. The building was constructed at 3 different times. The original building was constructed in 1919 and was determined to be of Type II (222)	K 000			

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K 000	Continued From page 2 construction. In 1939, an addition was constructed to the West Wing that was determined to be of Type II (222) construction. In 1961, an addition was constructed to the North Wing that was determined to be of Type II (222) construction. Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, they were surveyed as one building. Skilled Nursing Care is contained to a portion of the 2nd Floor of the Building The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 20 beds and had a census of 17 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke	K 324			7/11/25

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K 324	Continued From page 3 compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper inspection and safety measures associate to residential cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9). This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 05/20/2025 between 10:30 AM and 1:00 PM, it was revealed by observation that the residential stove-range located in the Activities Area was not outfitted with lock out and 120 min max timeout capability in the location of the device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	Vendor (Key Electric) will install lock out and timeout device for identified appliance within 30 days.		
K 353 SS=F	Sprinkler System - Maintenance and Testing	K 353			7/31/25

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K 353	Continued From page 4 CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.1, 5.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 05/20/2025 between 10:30 AM and 1:00 PM, it was revealed by a review of available documentation, that quarterly sprinkler system			K 353	Maintenance Director acknowledges missed documentation; will continue to conduct audits to minimize reoccurrence missing documentation related to quarterly sprinkler system testing. Deficiency identified during annual fire sprinkler system inspection associated to the FDC (fire department connection) to be corrected.		

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K 353	Continued From page 5 testing for Q3 and Q4 of 2024 was not available to confirm that testing had occurred. 2. On 05/20/2025 between 10:30 AM and 1:00 PM, it was revealed by a review of available documentation, that the most recent annual fire sprinkler system inspection (04/28/2025) identified a deficiency associated to the FDC (Fire Department Connection). At the time of Survey, deficiency had not been corrected. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353			
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 4.7, 19.7.1. This deficient finding could have a widespread impact on the residents within the facility.	K 712	Facilities maintenance to schedule fire drills at unexpected and varying times and complete thorough documentation regarding the fire drills.		6/30/25

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K 712	Continued From page 6 Findings include: On 05/20/2025 between 10:30 AM and 1:00 PM, it was revealed by a review of available documentation, that conducted fire drills exhibited patterning in dates and timestamps. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/20/2025. At the time of this survey, GUNDERSEN ST ELIZABETH'S CARE CENTER - BLDG 01 (SHIELD) found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/13/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. GUNDERSEN ST ELIZABETH'S CARE CENTER - BLDG 01 (SHIELD) is a 1 story building with full basement. The original building was constructed at 3 different times. The original building was constructed in 1970 and was determined to be of			K 000			

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K 000	Continued From page 2 Type II (111) construction. The Chapel addition is 1-story with full basement, constructed in December 2003 and was determined to be of Type II (111) construction. The Four Season Sun Room addition is 1-story with no basement, constructed 2012 and was determined to be of Type V (111) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 80 beds and had a census of 57 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K 000			
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for			K 353			6/9/25

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K 353	Continued From page 3 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.1, 5.2, 5.2.1.1.2(2)(5), 5.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 05/20/2025 between 1:00 PM and 3:30 PM, it was revealed by a review of available documentation, that quarterly sprinkler system testing for Q3 and Q4 of 2024 was not available to confirm that testing had occurred. 2. On 05/20/2025 between 1:00 PM and 3:30 PM, it was revealed by observation in the Social Service Office a sprinkler head exhibited signs of debris loading / oxidation. 3. On 05/20/2025 between 1:00 PM and 3:30 PM, it was revealed by observation in the Tub Room - 110, a sprinkler head exhibited signs of debris loading. 4. On 05/20/2025 between 1:00 PM and 3:30 PM, it was revealed by observation in the Janitorial Closet - 1016, the sprinkler head exhibited signs of debris loading.			K 353	Sprinkler head debris loading/oxidation addressed 6/9/2025.		

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K 353	Continued From page 4			K 353			
K 374 SS=E	An interview with the Maintenance Director verified these deficient findings at the time of discovery. Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 05/20/2025 between 1:00 PM and 3:30 PM, it was revealed by observation that smoke barrier door assembly - 1199A did not properly close and seal the opening, which would allow the passage of smoke.			K 374	Work order completed to address proper smoke barrier door closure.		6/10/25

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K 374	Continued From page 5 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374			
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 4.7, 19.7.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/20/2025 between 1:00 PM and 3:30 PM, it was revealed by a review of available documentation, that documentation was incomplete for 1st Shift - Q4 and 2nd Shift - Q1a additionally fire drill documentation exhibited patterning in dates and timestamps. An interview with the Maintenance Director verified these deficient findings at the time of	K 712	Facilities maintenance to schedule fire drills at unexpected and varying times and complete thorough documentation regarding the fire drills.		6/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245487		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2025	
NAME OF PROVIDER OR SUPPLIER GUNDERSEN ST ELIZABETH'S CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 712	Continued From page 6			K 712			
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			K 918			6/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245487	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER GUNDERSEN ST ELIZABETH'S CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FIFTH GRANT BOULEVARD WEST WABASHA, MN 55981		
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K 918	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to maintain the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section, 8.4, 5.6.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/20/2025 between 1:00 PM and 3:30 PM, it was revealed by a review of available documentation that vendor documentation identified that the generator battery was last changed 06/2022. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	Generator battery changed on 6/13/2025. The vendor erroneously identified that batteries were good for 3 years in both long term care and hospital settings.		