DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 7, 2025

Administrator
The Estates At Rush City LLC
650 Bremer Avenue South
Rush City, MN 55069

RE: CCN: 245348
Cycle Start Date: December 5, 2024

Dear Administrator:

On December 31, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT RUSH CITY LLC	650 BREMER AVENUE SOUTH RUSH CITY, MN 55069

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E 000	Initial Comments On 12/2/24 to 12/5/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 12/2/24 to 12/5/24 , a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H53481760C (MN00106577). H53481761C (MN00105062). H53481762C (MN00104193). H53481765C (MN00103090). H53481766C (MN00102740). H53481763C (MN00100920). H53481764C (MN00098330). 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	F 000		

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

Electronically Signed | 12/26/2024

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

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F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure blood sugars were obtained as ordered for 3 of 3 residents (R2, R7, R11) reviewed for blood glucose monitoring. Findings include: R2's Diagnosis Report dated 12/6/24, identified R2 had type 2 diabetes mellitus. R2's active orders as of 12/5/24, identified the following order: "Blood Sugars before meals and at bedtime" And: Novolog FlexPen 100 units per milliliter (ml) Solution pen-injector Inject as per sliding scale: 70 - 149 = 0 150 - 199 = 1	F 684	Nurse responsible was immediately removed from the schedule. Medication and Treatment Orders Policy, Medication Administration Policy and Infection Prevention and Control Policy were reviewed and remain accurate. Residents reviewed with diagnosis of diabetes, and appropriate orders are in place to obtain blood sugar before meals or as ordered. All licensed nurses and TMA's were educated on the Medication and Treatment Orders Policy & Medication Administration Policy with emphasis on obtaining blood sugar before	12/27/24

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F 684	Continued From page 2 200 - 249 = 2 250 - 299 = 3 300 - 349 = 4 350 - 399 = 5 400 - 999 = 6 subcutaneously with meals R7's Diagnosis Report dated 12/6/24, identified R7 had type 2 diabetes mellitus. R7's active orders as of 12/5/24, identified R7 required Humalog insulin per sliding scale: 70 - 149 = 0 150- 199 = 1 200 - 249 = 2 250 - 299 = 3 300 - 349 = 4 350 - 399 = 5 400 - 999 = 6 subcutaneously before meals R11's Diagnosis Report dated 12/5/24, identified R11 had type 2 diabetes mellitus with diabetic chronic kidney disease. R11's active orders as of 12/5/24, identified blood sugars needed to be checked three times a day. And: Humalog Injection Solution (Insulin Lispro) Inject as per sliding scale: 70 - 149 = 0 Units 150 - 199 = 8 units 200 - 249= 10 units 250 - 299 = 12 units 300 - 349 = 14 units; 350 - 399 = 16 units 400+ = 18 units 400 or greater give 18 units subcutaneously before meals On 12/4/24, at 12:53 p.m., licensed practical	F 684	meals and bedtime or as ordered and glucometer use related to infection control. All glucometers were removed from med carts and personal glucometers were placed in a plastic container in the resident rooms. No multi-use glucometer to remain in med cart. All licensed nurses and TMA's were educated on the Infection Prevention and Control Policy along with glucometer use and cleaning. Audits on infection control precautions with glucometer use and timeliness for residents who need blood sugars will be checked weekly x4 weeks, then monthly 2x months. Results of the audits will be shared with QA committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator or designee	

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F 684	Continued From page 3 nurse (LPN)-A was observed leaving the dining room wearing gloves and carrying a small plastic container with a glucometer (device to measure blood sugars) in the container. The glucometer had a used glucose strip in the machine. Registered nurse (RN)-A had stopped LPN-A and told her she could not wear gloves in the hallway. LPN-A removed her gloves and proceeded to R7's room carrying the plastic container with the glucometer and the used strip in the machine (LPN-A did not clean the glucometer) or remove the used strip. LPN-A entered R7's room and was then asked to step out. When LPN-A was in the hallway she stated she had planned to clean the glucometer once she was in the room and stated she "thought" there would be "wipes" in the room. LPN-A cleaned the shared glucometer with purple top wipes in R7's room. R7 stated she had already had her meal, LPN-A stated she could not find R7 before lunch. R7's glucometer reading was 224 milligrams (mg) per deciliter (dl). LPN-A then proceeded to R11's room, R11's meal was in his room, he stated he had finished eating. LPN-A cleaned the glucometer using the purple top wipes she had carried with her and obtained R11's blood sugar which was 244 mg/dl. LPN-A stated she had checked R2's blood sugar in the dining room. On 12/4/24, at 1:10 p.m., the director of nursing (DON) stated she would expect blood sugars to be obtained prior to residents eating their meals. The DON stated she did not have any training for LPN-A on glucometer use. The blood glucose monitoring check list included "verify practioner's order" as the first step in blood glucose monitoring. The DON stated she would expect any nurse to be trained on obtaining blood sugars as part of their nursing school education. The	F 684		

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F 684	Continued From page 4 DON stated she would expect nursing staff to clean a glucometer prior to placing the machine back in the container. The DON also stated each resident had their own glucometer and the glucometer LPN-A was using was only for emergencies.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure repositioning and checking and changing were offered for 1 of 3 residents (R12) reviewed for pressure ulcers. Findings include: R12's quarterly Minimum Data Set (MDS) dated 9/27/24, identified R12 had diagnoses which included fibromyalgia (a long-term condition that involves widespread body pain and tiredness), muscle weakness, hypothyroidism, unspecified mood disorder, restless leg syndrome, and acute	F 686	Staff were immediately educated on following a resident's care plan, always offering turning and reposition and if resident refused to notify nurse and document the refusal. Skin Assessment and Wound Management Policy was reviewed and remains current. Residents who are at risk for skin breakdown were reviewed to ensure proper treatment is being followed and care plan is updated with current interventions. All nursing staff were	12/27/24

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F 686	Continued From page 5 pain. R12's MDS identified R12 was cognitively intact, required substantial to maximum assistance with activities of daily living, was always incontinent of bowel and bladder, and was at risk for pressure ulcers. R12's nursing assistant care guide undated, identified staff were to assist with toileting every two to three hours and as needed and to turn and reposition every two to three hours and as needed. R12's care plan dated 2/16/24, identified R12 had an alteration in skin integrity, interventions included to turn and reposition every two to three hours and as needed. In addition, R12 had an alteration in elimination related to urinary incontinence, requiring staff assitance with toileting. Interventions included assist of one with toileting every two to three hours and as resident called. R12 orders dated 11/27/24, identified "When resident refusing cares i.e. washing up, changing, repositioning, dressing make a note. Reattempt, utilize other staff and update provider if continued refusals. Every shift" A review of R12's progress notes from 11/27/24, through 12/3/24, identified the following: -11/27/24 10:45 a.m., Risk versus benefits form filled out for refusing cares such as showering, turning/repositioning, am/pm cares, incontinence changes, getting up. Resident was educated on potential risks for non-compliance such as risk for infection, impaired skin integrity and pain. Residentwas understanding at this time.	F 686	educated on following current care plan and interventions with emphasis on reapproaching residents who refuse incontinence care and turning/repositioning, offering interventions and to notify nurse and document refusals. Audits of residents who are at risk for skin breakdown will be completed to ensure staff are following current care plan and interventions weekly x4 weeks, then monthly 2x months. Results of the audits will be shared with QA committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator or designee	

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F 686	Continued From page 6 -Several notes regarding topical ointments refused, no documented refusals of repositioning or checking and changing. During a continuous observation on 12/4/24 from 7:04 a.m., to 10:05 a.m., no offers were made by nursing staff to reposition, toilet, or check and change. During an interview on 12/4/24 at 9:55 a.m., nursing assistant (NA)-B stated she was responsible for R12's care. She stated she had not offered any cares and would only go in if R12 put her light on. NA-B stated she thought nights had checked on her before they left and R12 only liked certain people like "NA-A". NA-B stated she did not have a plan for checking and changing R12. During an interview on 12/4/24 at 10:01 a.m., NA-A stated no one had approached him with a plan for R12's care. NA-A stated R12 would often refuse cares but stated someone should still be offering repositioning and checking and changing every couple of hours. On 12/4/24 at 10:05 a.m., NA-A checked on R12 and asked her if she needed to be changed. R12 replied she thought she was okay and said the night person had changed her around 2:00 a.m., NA-A asked if he could check, R12 said ok but wanted privacy. During an interview on 12/4/24 at 10:19 a.m., NA-A stated R12 was wet, "not soaking" and said he would check in with her again after lunch. NA-A stated R12 said nights had last changed her between 1:00 a.m. and 2:00 a.m..	F 686		

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F 686	Continued From page 7 During an interview on 12/5/24 at 9:03 a.m., the director of nursing (DON) stated she would expect staff to offer cares, repositioning, and checking and changing even if the resident had a history of refusals. The DON stated she would expect the NA to tell the nurse and to document the refusals. The Skin Assessment and Wound Management policy dated 3/2024, identified pressure wounds wound be reviewed and the care plan would be updated including interventions.	F 686		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §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 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.	F 726		12/27/24

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F 726	Continued From page 8 §483.35(c) 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 nursing staff were appropriately trained and competent on blood glucose checks and infection control policies of the facility for 2 of 2 resident (R2, R7) who had their glucose checked. The facility also failed to confirm agency staff (staff brought in on a temporary basis to assist in resident cares) received facility and resident specific orientation and training prior to working with the residents. Findings include: The facility Temporary Agency Staff Orientation Checklist (TASOC) undated, indicated agency staff would be oriented to facility policies and practices that included emergency preparedness, abuse policy, use of mechanical lifts, medication systems and infection control. On 12/4/24, at 12:53 p.m., licensed practical nurse (LPN)-A was observed leaving the dining room wearing gloves and carrying a small plastic container with a glucometer in the container. The glucometer had a used glucose strip in the machine. Registered nurse (RN)-A had stopped LPN-A and told her she could not wear gloves in the hallway. LPN-A removed her gloves and proceeded to R7's room carrying the plastic	F 726	Immediately provided orientation to any agency staff on schedule that have not previously received. Agency Staff Orientation Checklist was reviewed and revised to ensure comprehensive orientation. Facility educated staff on proper orientation process with new agency providers, using the Agency Staff Orientation Checklist prior to their first shift. Facility identified agency providers who have not had orientation and provided orientation prior to starting their next scheduled shift. Review schedule daily to ensure all new agency staff are oriented prior to being assigned resident care. Audits of the schedule and Agency Staff Orientation Checklist/packet completion will be done weekly x4 weeks, then monthly 2x months. Results of the audits will be shared with QA committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator or designee	

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F 726	Continued From page 9 container with the glucometer and the used strip in the machine (LPN-A did not clean the glucometer) or remove the used strip. LPN-A entered R7's room and was then asked to step out. When LPN-A was in the hallway she stated she had planned to clean the glucometer once she was in the room and stated she "thought" there would be "wipes" in the room. LPN-A cleaned the shared glucometer with purple top wipes in R7's room. R7 stated she had already had her meal, LPN-A stated she could not find R7 before lunch. R7's glucometer reading was 224 milligrams (mg) per deciliter (dl). LPN-A then proceeded to R11's room, R11's meal was in his room, he stated he had finished eating. LPN-A cleaned the glucometer using the purple top wipes she had carried with her and obtained R11's blood sugar which was 244 mg/dl. LPN-A stated she had checked R2's blood sugar in the dining room. During an interview on 12/4/24 at 1:06p.m. LPN-A stated the facility had not given her any kind of orientation or training to the facility policy, procedures, or equipment prior to working with the residents and/or equipment. On 12/4/24 at 1:48 p.m., LPN-A's TASOC and schedule were reviewed. A blank TASOC with LPN-A's name was provided. LPN-A's working schedule indicated LPN-A's first shift at the facility as an agency nurse was on 11/30/24. On 12/4/24 at 1:50 p.m., registered nurse (RN)-B's TASOC and schedule were reviewed. RN-B's TASOC was completed and dated 12/4/24. RN-B's schedule indicated the first day worked as an agency nurse was 3/31/24.	F 726		

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F 726	Continued From page 10 During and interview on 12/4/24 at 1:00p.m. RN-B stated she could not remember if the facility gave her any kind of orientation or training to the facility policy, procedures, or equipment prior to working with the residents and/or equipment. RN-B did confirm the facility had just finished the orientation packet prior to the interview. During an interview on 12/5/24 at 10:18 a.m., the director of nursing (DON) reviewed the dates and education of LPN-A and RN-B. The DON confirmed the education was not completed the day of their first shift, but days later. The DON stated the expectation was that staff working with the new agency staff member would perform the checklist with the new staff member before they started work with the residents and equipment. A facility policy for orientation of agency staff was requested but not provided.	F 726		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 5.56 % with 2 errors out of 36 opportunities for error involving 2 of 7 residents (R9, R5) who were observed during the medication passes.	F 759	The nurse responsible was immediately removed from the schedule. The Medication and Treatment Orders Policy reviewed as well as the Medication Administration Policy and both remain current. All licensed nurses were educated on Medication and Treatment	12/27/24

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F 759	Continued From page 11 Findings include: R9: R9's quarterly Minimum Data Set (MDS) dated 11/7/24, identified R9 was cognitively intact and had diagnoses which included diabetes mellitus. R9's current order summary report dated 12/5/24, identified R9 had the following order: Lantus Solostar 100 unit per milliliter (ml) inject 10 units subcutaneously at bedtime On 12/2/24 at 6:21 p.m., licensed practical nurse (LPN)-B stated R9 liked to have his bedtime medications at 6:00 p.m.. LPN-B removed the glargine/lantus insulin from the drawer scrubbed the hub of the insulin pen with an alcohol wipe, dialed up 2 units of insulin, pushed the plunger expelling the insulin, dialed up 10 units of insulin and then put the needle onto the pen. LPN-B then entered R9's room to give the insulin. During an interview on 12/2/24 at 6:27 p.m., LPN-A verified she "primed" the pen prior to putting the needle on the insulin pen and stated that was how she always did it. R2: R2's annual MDS dated 9/11/24, identified R2 was moderately cognitively intact and and had diagnoses which included diabetes mellitus. R2's current order summary report dated 12/5/24, identified R2 had the following order: Insulin glargine 20 units subcutaneously in the	F 759	Order Policy and Medication Administration Policy with emphasis on proper priming of insulin pens. Completed orientation with new agency providers who work at facility. Audits to ensure nurse primes insulin pen for residents receiving insulin will be completed weekly x4 weeks, then monthly 2x months. Results of the audits will be shared with QA committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator or designee	

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	245348	A. BUILDING _____ B. WING _____	C 12/05/2024

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F 759	Continued From page 12 morning. On 12/4/24 at 8:49 a.m., LPN-A dialed up 20 units of insulin with the cover on the insulin pen and no needle, then placed the pen into the box with the glucometer. LPN-A stated R5 had already refused twice so she was going to ask registered nurse (RN)-B to give the insulin. RN-B went with LPN-A to the dining room, LPN-A dialed the pen back to zero. RN-B cleaned the top of the pen with an alcohol wipe, placed the needle on the pen, dialed 20 units, then brought R5 to his room, he refused the injection initially and then allowed RN-B to give the insulin. During on interview on 12/4/24 at 12:12 p.m., LPN-A stated she checks the insulin order, finds the right pen, checks for the number of units, dials up the units. When prompted about priming the needle LPN-A stated, "oh yes need to prime with one unit of insulin." During an interview on 12/4/24 at 12:16 p.m., the director of nursing stated it was her expectation nurses would cleanse the top of the insulin pen, place a needle, and then prime the needle with 2 units of insulin prior to dialing the insulin units. A policy on priming insulin pens was requested but not provided.	F 759		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		12/27/24

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F 880	Continued From page 13 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 14 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a shared glucometer was properly cleaned and disinfected between residents for 3 of 3 residents (R2, R7, R11) reviewed for blood glucose monitoring. Findings include: R2's Diagnosis Report dated 12/6/24, identified R2 had type 2 diabetes mellitus. R2's active orders as of 12/5/24, identified the following order: "Blood Sugars before meals and at bedtime" And: Novolog FlexPen 100 units per milliliter (ml) Solution pen-injector Inject as per sliding scale:	F 880	The nurse responsible was immediately removed from the schedule. The facility ensured residents had their own glucometer kit present in the room and multi-use glucometer removed from med cart. Infection Prevention and Control Policy was reviewed and remains current. All licensed nurses and TMA’s were educated on Infection Prevention and Control Policy with emphasis on the cleaning glucometers and individual glucometers in each resident room. Facility ensured all appropriate residents had their own personal glucometer kit. Completed orientation with new agency	

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F 880	Continued From page 15 70 - 149 = 0 150 - 199 = 1 200 - 249 = 2 250 - 299 = 3 300 - 349 = 4 350 - 399 = 5 400 - 999 = 6 subcutaneously with meals R7's Diagnosis Report dated 12/6/24, identified R7 had type 2 diabetes mellitus. R7's active orders as of 12/5/24, identified R7 required Humalog insulin per sliding scale: 70 - 149 = 0 150- 199 = 1 200 - 249 = 2 250 - 299 = 3 300 - 349 = 4 350 - 399 = 5 400 - 999 = 6 subcutaneously before meals R11's Diagnosis Report dated 12/5/24, identified R11 had type 2 diabetes mellitus with diabetic chronic kidney disease. R11's active orders as of 12/5/24, identified blood sugars needed to be checked three times a day. And: Humalog Injection Solution (Insulin Lispro) Inject as per sliding scale: 70 - 149 = 0 Units 150 - 199 = 8 units 200 - 249= 10 units 250 - 299 = 12 units 300 - 349 = 14 units; 350 - 399 = 16 units 400+ = 18 units 400 or greater give 18 units subcutaneously before meals	F 880	providers who work at facility. Audits to ensure resident specific glucometers were used and no multi-use glucometer in med cart on all appropriate residents will be completed weekly x4 weeks, then monthly 2x months. Results of the audits will be shared with QA committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator or designee	

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F 880	Continued From page 16 On 12/4/24, at 12:53 p.m., licensed practical nurse (LPN)-A was observed leaving the dining room wearing gloves and carrying a small plastic container with a glucometer (a device used to measure blood sugars) in the container. The glucometer had a used glucose strip in the machine. Registered nurse (RN)-A had stopped LPN-A and told her she could not wear gloves in the hallway. LPN-A removed her gloves and proceeded to R7's room carrying the plastic container with the glucometer and the used strip in the machine (LPN-A did not clean the glucometer) or remove the used strip. LPN-A entered R7's room and was then asked to step out. When LPN-A was in the hallway she stated she had planned to clean the glucometer once she was in the room and stated she "thought" there would be "wipes" in the room. LPN-A cleaned the shared glucometer with purple top wipes in R7's room using one wipe. LPN-A then proceeded to R11's room, R11 stated he had finished eating. LPN-A cleaned the glucometer using one wipe from the purple top wipes container that she had carried with her. She did not clean the glucometer after using the machine. On 12/4/24 at 1:03 p.m., LPN-A brought the plastic bin with the used glucometer and placed it on top of the medication cart. LPN-A did not clean or disinfect the glucometer machine prior to walking away from the cart. On 12/4/24, at 1:10 p.m., the director of nursing (DON) stated she did not have any training for LPN-A on glucometer use. The DON stated she would expect nursing staff to clean and disinfect a glucometer prior to placing the machine back in the container. The DON also stated each resident had their own glucometer and the glucometer	F 880		

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F 880	Continued From page 17 LPN-A was using was only for emergencies. On 12/4/24 at 1:18 p.m., LPN-A stated she "thought" she had wiped the glucometer off before putting it back in the box. LPN-A stated she thought the glucometer should stay wet for about "20 seconds". The document titled Blood glucose monitoring no date, identified the following: "Clean and disinfect the blood glucose meter with a disinfectant wipe, following the manufacturer's instructions wet/kill time. Contaminated blood glucose monitoring equipment increases the risk of infection by such blood borne pathogens as hepatitis B, hepatitis C, and human immunodeficiency virus ." The Assure Prism user instruction manual dated 2/2020, page 38 identified the following: Cleaning and Disinfecting: "The meter should be cleaned and disinfected after each use on each patient." The products listed were Clorox Healthcare bleach Germicidal Wipes -contact time 1 minute Dispatch Hospital Cleaner Disinfectant Towels with Bleach - contact time 1 minute CaviWipes1 - contact time 1 minute PDI Super Sani-Cloth Germicidal Disposable Wipe - contact time 2 minutes (purple top wipes) Cleaning: Wearing gloves using 1 towelette wipe the entire surface of the meter 3 times horizontally and 3 times vertically. Disinfecting: Pull out 1 new towelette and wipe the entire	F 880		

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F 880	Continued From page 18 surface of the meter 3 times horizontally and 3 times vertically. Allow the exteriors to remain wet for the corresponding contact time for each disinfectant.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 7, 2025

Administrator
The Estates At Rush City LLC
650 Bremer Avenue South
Rush City, MN 55069

Re: Reinspection Results
Event ID: RT5V12

Dear Administrator:

On December 31, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 5, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/2/24 to 12/5/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey with no licensing orders issued: H53481760C (MN00106577). H53481761C (MN00105062). H53481762C (MN00104193). H53481765C (MN00103090). H53481766C (MN00102740). H53481763C (MN00100920). H53481764C (MN00098330). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for	2 000		

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2 000	Continued From page 2 text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure direct-care nursing staff were appropriately trained and competent on blood glucose checks and infection control policies of the facility for 2 of 2 resident (R2, R7) who had their glucose checked. The facility also failed to confirm agency staff (staff brought in on a temporary basis to assist in resident cares) received facility and resident specific orientation and training prior to working with the residents.	2 300	corrected	12/27/24

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2 300	Continued From page 3 Findings include: The facility Temporary Agency Staff Orientation Checklist (TASOC) undated, indicated agency staff would be oriented to facility policies and practices that included emergency preparedness, abuse policy, use of mechanical lifts, medication systems and infection control. On 12/4/24, at 12:53 p.m., licensed practical nurse (LPN)-A was observed leaving the dining room wearing gloves and carrying a small plastic container with a glucometer in the container. The glucometer had a used glucose strip in the machine. Registered nurse (RN)-A had stopped LPN-A and told her she could not wear gloves in the hallway. LPN-A removed her gloves and proceeded to R7's room carrying the plastic container with the glucometer and the used strip in the machine (LPN-A did not clean the glucometer) or remove the used strip. LPN-A entered R7's room and was then asked to step out. When LPN-A was in the hallway she stated she had planned to clean the glucometer once she was in the room and stated she "thought" there would be "wipes" in the room. LPN-A cleaned the shared glucometer with purple top wipes in R7's room. R7 stated she had already had her meal, LPN-A stated she could not find R7 before lunch. R7's glucometer reading was 224 milligrams (mg) per deciliter (dl). LPN-A then proceeded to R11's room, R11's meal was in his room, he stated he had finished eating. LPN-A cleaned the glucometer using the purple top wipes she had carried with her and obtained R11's blood sugar which was 244 mg/dl. LPN-A stated she had checked R2's blood sugar in the dining room. During an interview on 12/4/24 at 1:06p.m. LPN-A	2 300		

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2 300	Continued From page 4 stated the facility had not given her any kind of orientation or training to the facility policy, procedures, or equipment prior to working with the residents and/or equipment. On 12/4/24 at 1:48 p.m., LPN-A's TASOC and schedule were reviewed. A blank TASOC with LPN-A's name was provided. LPN-A's working schedule indicated LPN-A's first shift at the facility as an agency nurse was on 11/30/24. On 12/4/24 at 1:50 p.m., registered nurse (RN)-B's TASOC and schedule were reviewed. RN-B's TASOC was completed and dated 12/4/24. RN-B's schedule indicated the first day worked as an agency nurse was 3/31/24. During and interview on 12/4/24 at 1:00p.m. RN-B stated she could not remember if the facility gave her any kind of orientation or training to the facility policy, procedures, or equipment prior to working with the residents and/or equipment. RN-B did confirm the facility had just finished the orientation packet prior to the interview. During an interview on 12/5/24 at 10:18 a.m., the director of nursing (DON) reviewed the dates and education of LPN-A and RN-B. The DON confirmed the education was not completed the day of their first shift, but days later. The DON stated the expectation was that staff working with the new agency staff member would perform the checklist with the new staff member before they started work with the residents and equipment. A facility policy for orientation of agency staff was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise	2 300		

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2 300	Continued From page 5 and implement policies and procedures related to administration of insulin and training of agency staff prior to their first shift. DON could provid training to the nurses anlong with completing competency skills in this area. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 300		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure repositioning and checking and changing were offered for 1 of 3 residents (R12) reviewed for pressure ulcers. Findings include: R12's quarterly Minimum Data Set (MDS) dated 9/27/24, identified R12 had diagnoses which included fibromyalgia (a long-term condition that involves widespread body pain and tiredness), muscle weakness, hypothyroidism, unspecified mood disorder, restless leg syndrome, and acute	2 905	corrected	12/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00994	A. BUILDING: _____ B. WING _____	C 12/05/2024

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2 905	Continued From page 6 pain. R12's MDS identified R12 was cognitively intact, required substantial to maximum assistance with activities of daily living, was always incontinent of bowel and bladder, and was at risk for pressure ulcers. R12's nursing assistant care guide undated, identified staff were to assist with toileting every two to three hours and as needed and to turn and reposition every two to three hours and as needed. R12's care plan dated 2/16/24, identified R12 had an alteration in skin integrity, interventions included to turn and reposition every two to three hours and as needed. In addition, R12 had an alteration in elimination related to urinary incontinence, requiring staff assitance with toileting. Interventions included assist of one with toileting every two to three hours and as resident called. R12 orders dated 11/27/24, identified "When resident refusing cares i.e. washing up, changing, repositioning, dressing make a note. Reattempt, utilize other staff and update provider if continued refusals. Every shift" A review of R12's progress notes from 11/27/24, through 12/3/24, identified the following: -11/27/24 10:45 a.m., Risk versus benefits form filled out for refusing cares such as showering, turning/repositioning, am/pm cares, incontinence changes, getting up. Resident was educated on potential risks for non-compliance such as risk for infection, impaired skin integrity and pain. Residentwas understanding at this time. -Several notes regarding topical ointments	2 905		

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2 905	Continued From page 7 refused, no documented refusals of repositioning or checking and changing. During a continuous observation on 12/4/24 from 7:04 a.m., to 10:05 a.m., no offers were made by nursing staff to reposition, toilet, or check and change. During an interview on 12/4/24 at 9:55 a.m., nursing assistant (NA)-B stated she was responsible for R12's care. She stated she had not offered any cares and would only go in if R12 put her light on. NA-B stated she thought nights had checked on her before they left and R12 only liked certain people like "NA-A". NA-B stated she did not have a plan for checking and changing R12. During an interview on 12/4/24 at 10:01 a.m., NA-A stated no one had approached him with a plan for R12's care. NA-A stated R12 would often refuse cares but stated someone should still be offering repositioning and checking and changing every couple of hours. On 12/4/24 at 10:05 a.m., NA-A checked on R12 and asked her if she needed to be changed. R12 replied she thought she was okay and said the night person had changed her around 2:00 a.m., NA-A asked if he could check, R12 said ok but wanted privacy. During an interview on 12/4/24 at 10:19 a.m., NA-A stated R12 was wet, "not soaking" and said he would check in with her again after lunch. NA-A stated R12 said nights had last changed her between 1:00 a.m. and 2:00 a.m.. During an interview on 12/5/24 at 9:03 a.m., the director of nursing (DON) stated she would	2 905		

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2 905	Continued From page 8 expect staff to offer cares, repositioning, and checking and changing even if the resident had a history of refusals. The DON stated she would expect the NA to tell the nurse and to document the refusals. The Skin Assessment and Wound Management policy dated 3/2024, identified pressure wounds wound be reviewed and the care plan would be updated including interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data	21390		12/27/24

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21390	Continued From page 9 collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a shared glucometer was properly cleaned and disinfected between residents for 3 of 3 residents (R2, R7, R11) reviewed for blood glucose monitoring. Findings include: R2's Diagnosis Report dated 12/6/24, identified R2 had type 2 diabetes mellitus. R2's active orders as of 12/5/24, identified the following order: "Blood Sugars before meals and	21390	corrected	

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21390	Continued From page 10 at bedtime" And: Novolog FlexPen 100 units per milliliter (ml) Solution pen-injector Inject as per sliding scale: 70 - 149 = 0 150 - 199 = 1 200 - 249 = 2 250 - 299 = 3 300 - 349 = 4 350 - 399 = 5 400 - 999 = 6 subcutaneously with meals R7's Diagnosis Report dated 12/6/24, identified R7 had type 2 diabetes mellitus. R7's active orders as of 12/5/24, identified R7 required Humalog insulin per sliding scale: 70 - 149 = 0 150- 199 = 1 200 - 249 = 2 250 - 299 = 3 300 - 349 = 4 350 - 399 = 5 400 - 999 = 6 subcutaneously before meals R11's Diagnosis Report dated 12/5/24, identified R11 had type 2 diabetes mellitus with diabetic chronic kidney disease. R11's active orders as of 12/5/24, identified blood sugars needed to be checked three times a day. And: Humalog Injection Solution (Insulin Lispro) Inject as per sliding scale: 70 - 149 = 0 Units 150 - 199 = 8 units 200 - 249= 10 units 250 - 299 = 12 units 300 - 349 = 14 units; 350 - 399 = 16 units	21390		

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21390	Continued From page 11 400+ = 18 units 400 or greater give 18 units subcutaneously before meals On 12/4/24, at 12:53 p.m., licensed practical nurse (LPN)-A was observed leaving the dining room wearing gloves and carrying a small plastic container with a glucometer (a device used to measure blood sugars) in the container. The glucometer had a used glucose strip in the machine. Registered nurse (RN)-A had stopped LPN-A and told her she could not wear gloves in the hallway. LPN-A removed her gloves and proceeded to R7's room carrying the plastic container with the glucometer and the used strip in the machine (LPN-A did not clean the glucometer) or remove the used strip. LPN-A entered R7's room and was then asked to step out. When LPN-A was in the hallway she stated she had planned to clean the glucometer once she was in the room and stated she "thought" there would be "wipes" in the room. LPN-A cleaned the shared glucometer with purple top wipes in R7's room using one wipe. LPN-A then proceeded to R11's room, R11 stated he had finished eating. LPN-A cleaned the glucometer using one wipe from the purple top wipes container that she had carried with her. She did not clean the glucometer after using the machine. On 12/4/24 at 1:03 p.m., LPN-A brought the plastic bin with the used glucometer and placed it on top of the medication cart. LPN-A did not clean or disinfect the glucometer machine prior to walking away from the cart. On 12/4/24, at 1:10 p.m., the director of nursing (DON) stated she did not have any training for LPN-A on glucometer use. The DON stated she would expect nursing staff to clean and disinfect a	21390		

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21390	Continued From page 12 glucometer prior to placing the machine back in the container. The DON also stated each resident had their own glucometer and the glucometer LPN-A was using was only for emergencies. On 12/4/24 at 1:18 p.m., LPN-A stated she "thought" she had wiped the glucometer off before putting it back in the box. LPN-A stated she thought the glucometer should stay wet for about "20 seconds". The document titled Blood glucose monitoring no date, identified the following: "Clean and disinfect the blood glucose meter with a disinfectant wipe, following the manufacturer's instructions wet/kill time. Contaminated blood glucose monitoring equipment increases the risk of infection by such blood borne pathogens as hepatitis B, hepatitis C, and human immunodeficiency virus ." The Assure Prism user instruction manual dated 2/2020, page 38 identified the following: Cleaning and Disinfecting: "The meter should be cleaned and disinfected after each use on each patient." The products listed were Clorox Healthcare bleach Germicidal Wipes -contact time 1 minute Dispatch Hospital Cleaner Disinfectant Towels with Bleach - contact time 1 minute CaviWipes1 - contact time 1 minute PDI Super Sani-Cloth Germicidal Disposable Wipe - contact time 2 minutes (purple top wipes) Cleaning: Wearing gloves using 1 towelette wipe the entire surface of the meter 3 times horizontally and 3 times vertically.	21390		

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21390	Continued From page 13 Disinfecting: Pull out 1 new towelette and wipe the entire surface of the meter 3 times horizontally and 3 times vertically. Allow the exteriors to remain wet for the corresponding contact time for each disinfectant. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies and complete staff education on infection control prcedures with use of insulin pens. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the proper procedures are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21390		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications.	21545		12/27/24

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21545	Continued From page 14 B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 5.56 % with 2 errors out of 36 opportunities for error involving 2 of 7 residents (R9, R5) who were observed during the medication passes.	21545	corrected	

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21545	Continued From page 15 Findings include: R9: R9's quarterly Minimum Data Set (MDS) dated 11/7/24, identified R9 was cognitively intact and had diagnoses which included diabetes mellitus. R9's current order summary report dated 12/5/24, identified R9 had the following order: Lantus Solostar 100 unit per milliliter (ml) inject 10 units subcutaneously at bedtime On 12/2/24 at 6:21 p.m., licensed practical nurse (LPN)-B stated R9 liked to have his bedtime medications at 6:00 p.m.. LPN-B removed the glargine/lantus insulin from the drawer scrubbed the hub of the insulin pen with an alcohol wipe, dialed up 2 units of insulin, pushed the plunger expelling the insulin, dialed up 10 units of insulin and then put the needle onto the pen. LPN-B then entered R9's room to give the insulin. During an interview on 12/2/24 at 6:27 p.m., LPN-A verified she "primed" the pen prior to putting the needle on the insulin pen and stated that was how she always did it. R2: R2's annual MDS dated 9/11/24, identified R2 was moderately cognitively intact and and had diagnoses which included diabetes mellitus. R2's current order summary report dated 12/5/24, identified R2 had the following order: Insulin glargine 20 units subcutaneously in the	21545		

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21545	Continued From page 16 morning. On 12/4/24 at 8:49 a.m., LPN-A dialed up 20 units of insulin with the cover on the insulin pen and no needle, then placed the pen into the box with the glucometer. LPN-A stated R5 had already refused twice so she was going to ask registered nurse (RN)-B to give the insulin. RN-B went with LPN-A to the dining room, LPN-A dialed the pen back to zero. RN-B cleaned the top of the pen with an alcohol wipe, placed the needle on the pen, dialed 20 units, then brought R5 to his room, he refused the injection initially and then allowed RN-B to give the insulin. During on interview on 12/4/24 at 12:12 p.m., LPN-A stated she checks the insulin order, finds the right pen, checks for the number of units, dials up the units. When prompted about priming the needle LPN-A stated, "oh yes need to prime with one unit of insulin." During an interview on 12/4/24 at 12:16 p.m., the director of nursing stated it was her expectation nurses would cleanse the top of the insulin pen, place a needle, and then prime the needle with 2 units of insulin prior to dialing the insulin units. A policy on priming insulin pens was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly administered. The quality assurance committee could monitor these measures to ensure compliance.	21545		

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21545	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		

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	245348	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/04/2024**

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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 on 12/04/2024. At the time of this survey The Estates at Rush City LLC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/26/2024

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	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT RUSH CITY LLC	**650 BREMER AVENUE SOUTH** **RUSH CITY, MN 55069**

(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 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Estates at Rush City LLC care center is a 1-story building with a partial basement constructed in 1967 of type II(111) construction. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245348	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/04/2024**

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K 000	Continued From page 2 to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 45 beds and had a census of 34 at the time of the survey. The requirements of 42 CFR, Subpart 483.70(a) are NOT MET as evidence by:	K 000		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames	K 363		12/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 363	Continued From page 3 shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 12/04/2024 at 09:34 AM, it was revealed by observation there are bi-fold doors in the east and west corridors for the clean linen that do not positively latch. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 363	The bi-fold doors in the east and west corridors for the clean linen were repaired so they positively latch. Any other bi-fold doors in the corridors were viewed to ensure they positively latch. Audits to ensure clean linen bi-fold doors in the east and west corridors positively latch will be completed weekly x4 weeks, then monthly 2x months. Results of the audits will be shared with QA committee for input on the need to increase, decrease or discontinue the audits. Corrections will be monitored by: Administrator or designee	