Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 17, 2025

Administrator
Augustana Care Hastings Health And Rehabilitation
930 WEST 16TH STREET
HASTINGS, MN 55033

RE: CCN: 245224
Cycle Start Date: May 23, 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 July 14, 2025. Additionally, the Minnesota Department of Public Safety completed a revisit on July 14, 2025 and a Federal Monitoring revisit on August 12, 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 on August 8, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 23, 2025 did not go into effect. (42 CFR 488.417 (b))

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 9, 2025

Administrator
Augustana Care Hastings Health And Rehabilitation
930 West 16th Street
Hastings, MN 55033

RE: CCN: 245224
Cycle Start Date: May 23, 2025

Dear Administrator:

On May 23, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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:

Stefanie Salberg, Regional Operations Supervisor
Metro B District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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 23, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 23, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245224	A. BUILDING _____ B. WING _____	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CARE HASTINGS HEALTH AND REHABILITATION	930 WEST 16TH STREET HASTINGS, MN 55033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 5/19/25 to 5/23/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/19/25 to 5/23/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		7/7/25

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

Electronically Signed | 06/18/2025

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 550	Continued From page 1 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this	F 550		

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F 550	Continued From page 2 subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident's needs were addressed in a respectful and dignified manner when a resident (R12) requested incontinence assistance. Findings include: R12's quarterly Minimum Data Set (MDS) dated 4/17/25, indicated R12 had intact cognition and diagnoses of cancer, anemia, hypertension, diabetes mellitus, psychotic disorder, and chronic obstructive pulmonary disease. R12 had hallucinations, verbal behaviors towards others, and did not reject cares. R12 was always incontinent of bowel and bladder. R12's bowel toileting program care plan revised 4/21/25, directed staff to offer bed pan after breakfast between 9:30 a.m. and 11:00 a.m. R12's activities of daily living (ADL) care plan related to toileting revised 4/21/25, indicated R12 was incontinent of bowel and bladder and required extensive assist of one staff for toileting. The care plan directed staff to check and change and/or offer bed pan upon arising, after meals, before bed and as needed. R12's ADL care plan related to transfers revised 4/21/25, indicated R12 required total assistance of two staff for transfers using a full body mechanical lift. R12's progress note dated 4/21/25 at 3:37 p.m., indicated: "BOWEL TOILETING PROGRAM: An individualized, resident specific toileting program was developed on 4/3/25, based on the assessment of the resident's unique bowel	F 550	Plan of Correction for Deficiency F550 It is the policy of Cassia to comply with the regulation cited under F550, which requires that residents' needs be addressed in a respectful and dignified manner. To assure continued compliance, the following plan has been put into place: " The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: o A Grievance was filed on behalf of R12 addressing timely response of request for assistance and request to use a commode o Residents care plan was reviewed and revised o Staff involved were counseled on the importance of timely and respectful response to resident needs. " Actions taken to identify other potential residents having similar occurrences: o A facility-wide review was conducted to identify any other residents who may have experienced delays in receiving incontinence assistance. Interviews with residents and staff were conducted to ensure no other similar occurrences were present. " Measures put in place to ensure deficient practice does not recur: o Staff will undergo training on resident dignity and timely response to care requests. o Nursing staff were educated that each	

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F 550	Continued From page 3 pattern in which the resident is to be offered the bed pan after breakfast between [9:30 a.m. and 11:00 a.m.]. She is at risk for impaired elimination related to diagnoses of COPD, rectal cancer, and Delirium aeb [as evidenced by] weakness and immobility. She is not always able to effectively communicate needs and request toileting. She requires total assist for check and change. She has a history of being frequently incontinent of bowel, but more recently bowel incontinence has increased to always incontinent. Most of her incontinent episodes occur following breakfast between 0930-1100, [9:30 a.m. - 11:00 a.m.) per staff. Resident would benefit from increased continence. During the reference period week of 4/11/25-4/17/25, the program was followed one day. Resident did not have a continent [bowel movement] during that time the program was carried out ...." During interview on 5/19/25 at 2:21 p.m., R12 stated she was incontinent "pooping and peeing" on herself and waited for staff assistance with cares for extended periods of time. During observation on 5/21/25 at 8:30 a.m., nursing assistant (NA)-G assisted R12's roommate with cares. At 8:44 a.m., NA-C wheeled R12 into the room after breakfast, and R12 stated "I just did it again" and needed a change. NA-C ensured R12 had call light within reach and left the room. At 8:48 a.m., NA-D entered the room to assist NA-G and R12's roommate. Shortly after, NA-D left the room and there was no mention R12 needed assistance. LPN-D entered the room to give R12's roommate medication and left. There was no mention R12 needed assistance. At 9:02 a.m., unknown nursing assistant entered the room to assist	F 550	resident has a right to request a change in their care and services provided, and that nurses and nurse managers need to be updated of resident request resident care plans and care guide sheets can be revised. " Effective implementation of actions will be monitored by: o The facility's Quality Assurance team will audit 20% of resident care episodes weekly for three months to ensure timely and respectful response to incontinence assistance requests. Results of these audits will be reviewed by the facility QAPI committee, which will decide if further monitoring/audits are recommended. " The person responsible to maintain compliance is: o Director of Nursing	

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F 550	Continued From page 4 NA-G and R12's roommate. R12 expressed she needed assistance and unknown nursing assistant assured R12 she would be assisted soon. LPN-D and unknown nurse entered the room to assist R12's roommate and brought a full mechanical lift into the room. During observation on 5/21/25 at 10:14 a.m., NA-G was in R12's room and finished cares with R12. R12 laid in bed, and R12 stated staff "finally" assisted her. During interview on 5/21/25 at 10:27 a.m., NA-G stated R12 was assistance of one with most cares and needed assistance of two staff for transfers with the full mechanical lift. NA-G stated R12 had a small incontinent bowel movement and offered R12 the bed pan, and R12 refused. NA-G stated R12 verbalized she wanted to use the toilet, and R12 was not able to since she transferred with a full mechanical lift. NA-G stated she would redirect R12 and told R12 staff would help her with incontinent cares. During interview on 5/21/25 at 1:09 p.m., R12 was in bed and stated she did not use the toilet and was able to tell when she needed to use the bathroom. R12 stated she used a full mechanical lift to transfer so was not able to get to the toilet. R12 stated she did not like to use the bed pan, because the bed pan was hard and uncomfortable. R12 stated use of a commode was brought up in conversation before but had not used a commode. R12 stated it was important for her to stay dry and was "hurt", with a tear down her face, when asked about incontinence cares. During interview on 5/21/25 at 1:52 p.m., NA-G	F 550		

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F 550	Continued From page 5	F 550		

stated R12 called when she needed a change in incontinence product and/or checked R12 every couple of hours. NA-G stated R12 needed more incontinence assistance than usual today.

During interview on 5/22/25 at 11:18 a.m., licensed practical nurse (LPN)-E stated a staff member should respond to a resident's request after they finished assistance with the current resident. LPN-E stated R12 was incontinent and used a full mechanical lift. LPN-E stated residents who used a mechanical lift could use a commode and did not believe R12 tried a commode. LPN-E did not know if R12 was able to sense when she needed to use the restroom or wanted to use the toilet and stated the nursing assistants knew more about R12.

During interview on 5/22/25 at 11:42 a.m., registered nurse (RN)-B staff should assist a resident within five to 10 minutes when resident asked for incontinence assistance. RN-B stated RN-D assessed bowel and bladder programs on a quarterly basis. RN-B stated R12 had a bowel program and followed the standard urinary incontinence cares of assistance upon rising, between meals, at bedtime and as needed. RN-B was not aware of any trial of a commode and stated the interdisciplinary team usually discussed commode use when bowel and bladder programs were reviewed. RN-B was not aware R12 requested toilet use.

During interview on 5/22/25 at 2:51 p.m., RN-D stated they reviewed residents' bowel and bladder programs during their MDS assessment period. RN-D stated they reviewed residents' chart and interviewed staff and residents to assess bowel and bladder programs. RN-D stated R12 recently

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F 550	Continued From page 6 started a bowel program when staff stated R12 had the urge to have a bowel movement after breakfast. RN-D did not "know how to answer that one" when asked about a bladder program. RN-D was not aware of any bowel and bladder concerns for R12. During follow-up interview on 5/23/25 at 8:46 a.m., NA-G stated they were with R12's roommate from approximately 8:00 a.m. and 9:00 a.m.. NA-G stated they answered a couple other call lights before they assisted R12, while they waited for assistance to transfer R12 into bed. During interview on 5/23/25 at 9:45 a.m., the director of nursing (DON) stated R12 was not always able to request toileting assistance before an incontinence episode. DON expected staff to communicate with nurses or nurse managers about bowel and bladder concerns to assess if there could be gains of continence for residents. The DON expected staff to prioritize to meet residents' needs. The facility's Resident Rights policy dated 11/15/24, indicated "Cassia facilities recognize that they must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident."	F 550		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		7/7/25

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F 684	Continued From page 7 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 a resident with known heart failure was routinely assessed for new or worse symptoms as directed by the discharging hospital physician for 1 of 1 resident (R15). In addition, the facility failed to comprehensively assess a non-pressure skin condition, to ensure wound change could be adequately monitored and acted upon promptly to promote healing and reduce the risk of complication (i.e., infection, worsening) for 1 of 2 residents (R51) reviewed who had skin impairments. Finding include: R15 R15's admission Minimum Data Set (MDS) dated 5/11/25, indicated R15 was admitted to the care facility on 5/5/25, had mild cognitive impairment, and an active diagnosis of peripheral vascular (or arterial) disease (a condition where narrowed arteries reduce blood flow to the arms and legs). R15's Hospital discharge note, dated 4/24/25 - 5/5/25, directed the care facility staff to monitor for signs of heart failure daily and "more frequently as condition warrants" including; assessing lung sounds daily, assessing for	F 684	F684 Plan of Correction It is the policy of Cassia to comply with the regulation cited under F684. To assure continued compliance, the following plan has been put into place: " The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: o Resident R15 discharged to home on 5/22/25; record review indicated that resident did not have a diagnosis of CHF nor did his record review indicate any signs and symptoms of congestive heart failure. Resident R51 will receive a comprehensive assessment of the non-pressure skin condition to ensure proper monitoring and prompt action to promote healing. " Actions taken to identify other potential residents having similar occurrences: o A review of all residents with heart failure and skin impairments will be conducted to identify any who have not been routinely assessed or comprehensively evaluated for their conditions. " Measures put in place to ensure deficient practice does not recur: o Staff will receive training on the	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 8 peripheral edema daily, measuring oxygen saturations daily at rest and with activity, and to notify the physician with any change in patient condition or worsening heart failure symptoms. R15's electronic medical record (EMR), including the Care Plan, Active Orders, and Progress Notes, all printed 5/22/25, lacked any direction for nursing staff to monitor R15 for signs and symptoms of worsening heart failure. The EMR lacked documentation of R15's edema and lung sounds. The EMR indicated R15's oxygen saturations were checked daily but did not indicate if the measurement was at rest or with activity. During observation on 5/29/25 at 1:54 p.m., R15 was sitting in his recliner chair in his room with a family member present. R51's bilateral hands appeared edematous. R15's family member stated she believed R15 was wearing some compression sleeves at the hospital but not any since being admitted to the care facility. During an interview on 5/21/25 at 12:16 p.m., registered nurse (RN)-C stated R15 did not have any routine orders for daily assessment, stating some residents would have ordered routine assessments, otherwise assessments would only be completed and charted on if there was a noted concern. During an interview on 5/22/25 at 8:00 a.m., nurse manager and assistant director of nursing (ADON) stated every resident in the transitional care unit had daily weights completed, however many times a resident would have specific orders regarding monitor shortness of breath, edema, lung sounds, etc. The ADON confirmed R15 left	F 684	importance of routine assessments for heart failure symptoms by using the CHF order set and Wound management for any new skin conditions. o A checklist will be implemented to ensure the CHF order sets are completed as required. o Review of progress notes and review of Wound management will be reviewed by nurse managers to ensure wound management documentation is completed per facility policy. " Effective implementation of actions will be monitored by: o The nursing supervisor will audit all new admissions for diagnosis of heart failure to ensure routine assessments are in place; this will occur weekly for three months to ensure compliance with routine assessments for heart failure. The nursing supervisor will audit progress notes to ensure that wound manager is opened per facility protocol; this will occur weekly for three months to ensure compliance with routine assessments for comprehensive skin evaluations. Results of these audits will be reviewed by the facility QAPI committee, and they will make the decision if further monitoring/audits are recommended. " The person responsible to maintain compliance is: o Director of Nursing	

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F 684	Continued From page 9	F 684		

the hospital with directions to monitor R15 for "signs of heart failure daily", stating she would expect to see the documentation in a progress note or medication administration record, confirming it was not there. The ADON stated the care community had good continuity of care but agreed it would be difficult to determine if R15 had worsening heart failure if his daily status was not being assessed and documented.

R51

R51's admission Minimum Data Set (MDS) dated 4/22/25, indicated R51 had moderately impaired cognition and was diagnosed with heart failure, liver cirrhosis (chronic liver disease causing scarring, and decreased liver function), and polyneuropathy (a condition causing weakness, numbness, and pain in the feet and hands). The MDS indicated R51 had no ulcers or other open lesions of the foot.

R51's care plan dated 4/17/25, indicated R51 was at risk for an alteration of skin integrity related to heart failure, liver disease, and edema in her legs. The care plan indicated that licensed staff were to complete a visual body observation weekly, implement appropriate interventions for any areas of concern, and notify the provider and family of these new areas. The care plan indicated the nursing assistants (NA) were to observe skin daily during cares and notify the nurse promptly of any areas of concern.

R51's Comprehensive Skin Risk and Braden assessment dated 4/16/25, indicated R51 was "at risk" for skin breakdown (with a score of 17) related to decreased activity, nutrition level, and shear/friction risk. The assessment indicated R51

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F 684	Continued From page 10 had bruises present but had no infections, ulcers, or open lesions of the foot, no burns, skin tears, rash/abrasion, skin tear/laceration, or moisture-associated skin damage (MASD). The assessment did not include documentation of any other skin injuries to the foot. The document indicated the NAs were to complete a "daily skin assessment" and the licensed nurse would complete an assessment weekly. The Comprehensive Skin Risk and Braden assessment was completed on: - 4/23/25 and indicated R51 had bruising with none of the other skin alterations as outlined above. - 4/30/25 and indicated R51 had none of the skin alterations as outlined above, and bruising was not present. - 5/7/25 and indicated R51 had none of the skin alterations as outlined above and R51 continued with no bruising. - 5/14/25 and indicated R51 had an "open lesion(s) on the foot" but did not include a further description of this lesion. R51 continued to have bruising. R51's Visual Body Observation dated 4/16/25, did not indicate R51 had a wound to her right great toe. The Visual Body Observation was also completed on 4/23/25, and 5/7/25, and did not indicate that R51 had a wound to her right great toe. The observation dated 5/14/25, included a section titled "Describe any additional new alterations in the skin from above or otherwise noted" and the section did not include a description of any wound to R51's right great toe, nor did the rest of the documentation. R51's Medication Administration Record (MAR) dated 5/1/25 to 5/19/25, included an order	F 684		

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F 684	Continued From page 11 starting on 5/14/25, to apply a thin layer of bacitracin to R51's right great toe and cover daily until the "wound" was healed. The order was completed daily from 5/14/25 to 5/19/25. R51's progress note dated 5/8/25 at 9:46 p.m., indicated R51 had requested the registered nurse (RN) to check her right great toe because it "feels tender" and noted an old scab and dry skin "from a healed blister" that was partially falling off. The note indicated that R51 requested the dry skin be removed entirely and the RN applied bacitracin (an antibiotic ointment) to the area. R51's progress note dated 5/12/25 at 10:28 p.m., indicated R51's "entire tip of right big toe has a sore on it". The note indicated R51's right big toe had a dressing covering it, that the resident said had not been changed in approximately five days. R51 complained of soreness and asked for her dressing to be changed. The note indicated RN-A had cleansed the sore with saline, applied bacitracin, and covered the wound with gauze and tape. The note did not include a physical description of this sore or measurements. R51's progress notes dated 5/17/25 at 11:49 p.m., and 5/18/25 at 11:00 p.m., indicated that R51's dressing to the right big toe was changed as ordered. The notes did not include a physical description of this sore or measurements. R51's progress notes dated 5/8/25, through 5/19/25, were reviewed and did not include any further description of R51's wound to her right great toe. R51's Wound Management tab printed on 5/20/25 at 8:56 a.m., indicated no active, healed, or discontinued wounds had been documented under this tab since admission on 4/16/25.	F 684		

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F 684	Continued From page 12 R51's Wound Details dated 5/20/25 at 2:52 p.m., indicated R51 had a wound to her "right big toe" with a specific wound type of "trauma from bumping it?" that measured .5 cm by .5 cm. The wound was described as a small dry area and R51 had thought she bumped it. The note indicated R51 had no "pressure forces" and wore socks and slippers. R51's medical record was reviewed and no further descriptions of R51's wound to her right great toe were found. During an interview on 5/20/25 at 1:12 p.m., R51 stated she didn't have a wound on her toe when she was admitted. R51 stated she thought her sock was too tight about a month ago and had rubbed on her toe and caused a wound to open up. R51 stated "It [the wound] was ugly" and someone had applied a dressing to her toe when they had first found it. During an interview and observation on 5/20/25 at 1:20 p.m., licensed practical nurse (LPN)-A confirmed she was R51's nurse. LPN-A stated that R51 had no skin issues at the moment and if she did, she could find it under the observations tab. LPN-A stated they would put in on the visual body observations and it should be documented there, and all she saw documented were a scattering of bruises. LPN-A stated the skin was assessed every week on bath day or if something was reported by the aides. LPN-A stated if they had found something new they would open up an event, get an order for wound care, and then should open up "something" so they would continue to monitor it. On request, LPN-A examined R51's right foot, and a small pink	F 684		

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F 684	Continued From page 13 wound was noted to the end of R51's right great toe and R51 stated the wound "hurts very much so". During an interview on 5/21/25 at 7:56 a.m., the assistant director of nursing (ADON) stated she followed residents with chronic wounds, or wounds that were more challenging or having a hard time healing. The ADON stated she was not following any residents in R51's unit. At 10:30 a.m., the ADON stated she would expect a full head-to-toe skin assessment to be completed on admission and then if there were any abnormalities, she would expect them to add a record to "wound management" if any new wounds were found so they wounds could be tracked. The ADON confirmed that she had reviewed R51's record but did not see a wound management note, that would include measurements or a description from when the wound was found/before survey entrance. During an interview on 5/21/25 at 11:12 a.m., nurse practitioner (NP)-A stated she had been notified of the wound to R51's right toe so she had assessed it on 5/14/25 on her visit but had not documented this. NP-A stated the wound was pink in color and she wanted a daily dressing change for it, so she had put in the order for the bacitracin and gauze. NP-A stated she did not feel that the wound was caused by pressure but was possible the wound was caused by R51 bumping her toe and not noticing related to her polyneuropathy. During an interview on 5/21/25 at 2:01 p.m., registered nurse (RN)-A stated she remembered the day of 5/14/25, when R51 had told her that her toe was hurting, and she had a dressing on it	F 684		

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F 684	Continued From page 14 but the dressing didn't have a date on it so she was unsure how long it had been on there. RN-A stated the tape was very stuck to R51's skin and she had to use saline to get the dressing off. RN-A stated when she did get the dressing off of R51's big toe, a scab came off with it and a wound was present underneath. RN-A stated there was a small open wound underneath the scab but was unable to describe it in further detail. During an interview on 5/22/25 at 10:06 a.m., the director of nursing (DON) stated that she would expect nursing staff to open a wound management assessment if a new wound was discovered so the wound could be tracked. The facility Skin Integrity policy dated 3/10/25, indicated the facility staff would use the Wound Management area to document "skin integrity issues". The policy indicated if, on a daily skin check by the NA, an alteration was noted, the nurse would follow the documentation guidelines below for "any new skin alterations". The policy indicated staff were to document the skin alteration's specific location, physical description, and measurements. The policy included a section titled "Measuring/Describing Wounds" and included 14 items including the location of the wound, type of wound, measurements (length, width, depth), tissue types (epithelial, granulation, slough, eschar/slough, red/pink, etc), if drainage is present (and description if so), odor, pain, wound edge description, etc.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		7/7/25

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F 695	Continued From page 15 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure oxygen administration was administered according to physician orders for 1 of 1 resident (R11) observed for respiratory services. Findings include: R11's face sheet printed 5/22/25, indicated R11 had a diagnosis of chronic respiratory failure with hypoxia (a condition where the lungs struggle to provide enough oxygen to the blood, leading to low oxygen levels in the body). R11's significant change Minimum Data Set (MDS) dated 5/15/25, indicated R11 was on hospice, had moderate cognitive impairment, received maximal assistance with oral hygiene, eating, showers, upper body dressing, personal hygiene and was dependent with bed mobility, transfers, toileting hygiene and lower body dressing. R11's MDS indicated resident received oxygen therapy and identified diagnoses of dementia, chronic obstructive pulmonary disease, and respiratory failure. R11's orders printed 5/22/25, indicated orders for 2 to 4 liters of oxygen, continuous via nasal cannula to maintain SAO2 (arterial oxygen	F 695	F695 Plan of Correction It is the policy of Cassia to comply with the regulation cited under F695, ensuring that oxygen administration is conducted according to physician orders. To assure continued compliance, the following plan has been put into place: " The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: Resident R11's oxygen administration was immediately reviewed and adjusted to align with the physician's orders. A Medication error event was created, and education was provided to the nurse and nursing assistant involved. The resident's care plan was reviewed, and staff were re-educated on the importance of adhering to physician orders for oxygen administration. " Actions taken to identify other potential residents having similar occurrences: A facility-wide audit was conducted to review the oxygen administration records of all residents receiving respiratory services to ensure compliance with physician orders. " Measures put in place to ensure deficient practice does not recur: Staff will	

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F 695	Continued From page 16 saturation) over 90%. R11's care plan printed 5/22/25, indicated "I require oxygen therapy related to restrictive lung disease/chronic respiratory failure." R11's care plan goal indicated "I will not exhibit signs of hypoxia (cyanosis, dyspnea, confusion, restlessness, nasal flaring, elevated blood pressure, increased respirations, increased pulse)". The care plan interventions indicated the administration of oxygen at 2 liters per minute (Lpm) via nasal cannula (NC). R11's Medication administration record (MAR) printed 5/22/25, indicated oxygen 2 Lpm to 4 Lpm via NC, continuous to maintain SAO2 (oxygen level in blood) at 90% for a diagnosis of respiratory failure with hypoxia. During observation on 5/19/25 at 2:00 p.m., R11 was sleeping in bed in supine position she had an oxygen nasal cannula on her nares, and the oxygen tank was not on. R11 appeared to be resting comfortably with no signs of respiratory distress. During observation on 5/19/25 at 4:35 p.m., R11 was in bed awake, restless, and her respirations were rapid and labored. R11's oxygen nasal cannula was under her chin and the oxygen tank was not on. During observation on 5/19/25 at 4:38 p.m., surveyor left the room to obtain staff assistance, while licensed practical nurse (LPN)-C and a nursing assistant (NA) entered R11's room. Staff exited R11's room within two minutes. During observation on 5/19/25 at 4:40 p.m.,	F 695	receive ongoing training on the importance of following physician orders for oxygen administration. A checklist will be implemented for each shift to verify that oxygen administration aligns with current physician orders. " Effective implementation of actions will be monitored by: The facility will audit 20% of resident charts receiving respiratory services weekly for three months to ensure compliance with physician orders for oxygen administration. Results of these audits will be reviewed by the facility QAPI committee, which will decide if further monitoring/audits are recommended. " The person responsible to maintain compliance is: Director of Nursing	

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F 695	Continued From page 17 surveyor returned to the room to check on R11 and R11 was in bed laying on her left side with the oxygen cannula on her nares but the oxygen tank was not on. Surveyor left the room again to obtain staff assistance. LPN-C returned to the room with surveyor. During observation and interview on 5/19/25 at 4:41 p.m., LPN-C stated R11 had an order for continuous oxygen to keep her SAO2 above 90%. LPN-C stated R11 removed her nasal cannula but now it's on her nares. LPN-C was interviewed at R11's bedside, and confirmed the oxygen tank was not on. LPN-C stated "It's always on. Maybe when they laid her [R11] down in bed after lunch, they [nursing assistants] didn't start the oxygen." LPN-C verified R11's breathing was rapid and appeared to be short of breath. LPN-C turned oxygen on at 2 liters, checked R11's O2Sats (oxygen saturation) and it was 69%. LPN-C instructed R11 to take deep breaths, O2Sats increased to 74%. LPN-C increased the oxygen to 4 Lpm and after a couple minutes, R11's O2Sats were 93%. R11's electronic medical record (EMR) lacked documentation regarding R11 being without oxygen on 5/19/25, and her SAO2 dropping below 90%. R11's Safety event described as a Medication Incident dated 5/20/25, indicated no vitals were recorded and there were no associated progress notes or additional details included for the event. During observation and interview on 5/21/25 at 7:21 a.m., nursing assistant (NA-E) switched R11's oxygen tank cannula with the portable oxygen tank's cannula and turned on the portable	F 695		

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F 695	Continued From page 18 tank to 2 Lpm. NA-E stated he asked the nurse what R11's oxygen liter flow should be before he switched the cannula. During interview on 5/21/25 at 10:03 a.m., LPN-D stated this morning R11's O2Sats were 96% at 2 Lpm via her portable oxygen tank. During interview on 5/22/25 at 8:48 a.m., LPN-E stated the nurses monitored O2Sats and respiratory status of residents receiving oxygen. LPN-E stated the NAs were allowed to switch residents from a portable to a stationary oxygen unit, keeping the same oxygen liter. LPN-E stated if a resident O2Sats dropped under 90%, the nurse needed to make a progress note and report to the next nurse. During interview on 5/22/25 at 9:30 a.m., nurse manager/register nurse (RN)-B stated NAs were responsible for placing and switching between the portable and stationary oxygen tank. RN-B stated the nurses were responsible to monitor O2Sats levels, oxygen liter flow, replacing the oxygen tubing, and oxygen bubbler. RN-B stated when a resident had an incident like R11's, the expectation was for nurses to document and update the providers. RN-B verified there was not documentation about R11's oxygen incident. During interview on 5/22/25 at 12:55 p.m., director of nursing DON stated R11's oxygen incident was brought to her attention on 5/19/25. DON stated the nurse practitioner and guardian were updated about incident as a medication error. DON stated she has been monitoring R11's O2Sats and as soon as they learned about this incident, the staff was re-educated. DON indicated the staff was very aware of the need to	F 695		

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F 695	Continued From page 19 ensure residents were receiving oxygen as ordered. Facility's policy titled Oxygen: Liquid Stationary dated 3/10/25, indicated oxygen will be administered per order.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to appropriately monitor and comprehensively assess complaints of pain for 1 of 5 residents (R2) reviewed for pain. Findings include: R2's quarterly Minimum Data Set (MDS) dated 3/13/25, indicated R2 had intact cognition, no hallucinations, delusions, behaviors, or rejection of care. R2 was independent with most activities of daily living and had diagnoses which include seizure disorder, depression, and psychotic disorder. The MDS indicated R2 received scheduled pain medication, as needed pain medication, and non-medication interventions for pain. The MDS indicated R2 had frequent pain and rated pain at a four. The MDS indicated R2's pain frequently affected sleep and occasionally interfered with day-to-day activities.	F 697	F697 Plan of Correction It is the policy of Cassia to comply with the regulation cited under F697, which pertains to the appropriate monitoring and comprehensive assessment of pain complaints. To assure continued compliance, the following plan has been put into place: " The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: Resident R2 will receive a comprehensive pain assessment by the nursing staff, and R2 care plan will be revised immediately. " Actions taken to identify other potential residents having similar occurrences: All residents have a current comprehensive pain assessment completed by the nursing staff. " Weekly pain monitoring will be placed in all residents charts. If rating pain >3	7/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245224	A. BUILDING _____ B. WING _____	05/23/2025

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AUGUSTANA CARE HASTINGS HEALTH AND REHABILITATION	930 WEST 16TH STREET HASTINGS, MN 55033

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F 697	Continued From page 20 R2's pain care plan reviewed and/or revised 3/19/25, indicated R2 had a history of pain related to fibromyalgia (long-term condition which involves widespread body pain), chronic pain, diabetes, neuropathy, restless leg syndrome (nearly irresistible urge to move the legs; may experience pain), depression, and gastroesophageal reflux disease. R2 was able to verbalize pain and pain relief. Interventions included to follow PRN (as needed) analgesic house orders for pain, provide non-medication pain relief, such as rest and position changes, notify provider of any new or unrelieved pain, monitor for non-verbal signs and symptoms of pain, complete pain assessment on admission, quarterly, and as needed, give pain medication as ordered, monitor for pain medication side effects and notify provided if noted. R2's mood state care plan reviewed/revised 3/31/25, indicated pain was a situation which caused mood difficulty. The care plan indicated R2 became excessively focused on pain and health condition which became a barrier to having a quality of life. R2's pain focus may cause irritability, accusations towards staff and care, and belief R2 was not receiving proper care and services. R2's behavioral symptoms care plan reviewed/revised 3/31/25, indicated R2 had history of inappropriate use of over-the-counter analgesic medication due to a fear of being in pain. R2's associated clinic of psychology care plan reviewed/revised 3/31/25, indicated pain may affect mood and spending time out of bed doing previous hobbies.	F 697	will complete a new comprehensive pain assessment and notify the MD/NP unless the residents pain management goal is otherwise noted. " Measures put in place to ensure deficient practice does not recur: All nursing staff will undergo training on the facility's pain assessment protocol, emphasizing the importance of updates to the provider when pain is not appropriately managed. " Effective implementation of actions will be monitored by: The nursing supervisor will review each residents weekly pain ratings to ensure effective pain management. This review will be conducted weekly for a duration of three months. The findings from these audits will be submitted to the facility's QAPI committee for evaluation, and the committee will determine whether ongoing monitoring or additional audits are necessary. " The person responsible to maintain compliance is: The Director of Nursing.	

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F 697	Continued From page 21 R2's cognition care plan reviewed/revised 3/31/25, indicated pain may affect cognition. R2's sleep care plan reviewed/revised 5/20/25, indicated R2 slept through the night without difficulties and was able to report alterations in sleeping patterns. Interventions included to offer pain medications as needed. R2's Pain-Comprehensive Observation dated 3/27/25, indicated R2 had "moderate aching pain" in her head caused by migraines and was not feeling well with the "stomach flu". The assessment indicated rest and medication helped R2's pain, and movement made R2's pain worse. The assessment indicated anxiety and verbal expressions of pain was how resident expressed pain. The assessment indicated R2 had chronic pain and pain goals included sleep comfortably, comfort with movement, comfort at rest, and prefers to stay alert rather than increasing amount of pain medications or other sedating medications taken. R2's physician orders included the following scheduled medications: -10/6/20, pregabalin 100 mg (milligrams) by orally three times a day for fibromyalgia. -1/12/21, voltaren gel 1% 2 grams topically to right shoulder and bilateral knees four times a day for pain. -4/22/22, acetaminophen (pain reliever and fever reducer) 1,000 mg orally three times a day. -12/27/22, ropinirole 0.125 mg once a day one hour before bed for restless leg syndrome. -2/21/25, hydromorphone 1 mg orally twice a day and 2 mg orally twice a day for pain. -3/6/25, Topamax (anticonvulsant and nerve pain	F 697		

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F 697	Continued From page 22 medication) 50 mg twice a day. R2's physician orders included the following PRN medications: -7/12/22, acetaminophen 1,000 mg orally for pain 1 to 3 out of 10. Non-pharmacological interventions: 1= Warm blanket, 2= re-position, 3= Ice pack, 4= Warm pack, 5= Aromatherapy. Once a day PRN. -2/21/25, hydromorphone 2 mg orally for pain 4-10 out of 10. Non-pharmacological interventions: 1= Warm blanket, 2= re-position, 3= Ice pack, 4= Warm pack, 5= Aromatherapy. Every four hours PRN. -3/25/25, Topamax 25 mg for headache. Non-pharmacological interventions: 1= Warm blanket, 2= re-position, 3= Ice pack, 4= Warm pack, 5= Aromatherapy. Once a day PRN. R2's vitals reviewed from 2/1/25 to 5/22/25, lacked evidence of R2's pain rating or scale. R2's progress note dated 4/27/25 at 10:26 p.m., indicated "[R2] was "steaming" mad tonight. (Her words). She doesn't understand why she can't have enough pain meds for her back pain. [R2] never asked for any additional pain medication all shift." No follow-up was noted in R2's electronic health record. R2's medication administration record and progress notes during the time of medication administration were reviewed from 4/27/25 to 5/20/25 and indicated the following: -acetaminophen 1,000 mg PRN was administered during the night shift 19 out of 24 days. Five of the 19 days did not have a pain rating (verbal rating or use of non-verbal pain scale) or location documented. Three of the 19	F 697		

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F 697	Continued From page 23 days lacked a pain rating (verbal rating or use of non-verbal pain scale). One of the 19 days did not describe pain location. Non-pharmacological interventions were documented, and treatment was marked as effective. -hydromorphone 2 mg PRN was administered during the night shift 20 out of 24 days. Six of the 20 days did not have a pain rating (verbal rating or use of non-verbal pain scale) or location documented. Three of the 19 days lacked a pain rating (verbal rating or use of non-verbal pain scale). One of the 19 days did not describe pain location. Non-pharmacological interventions were documented, and treatment was marked as effective. A further review of R2's progress notes dated 4/27/25 to 5/20/25, indicated the following related to pain: -On 5/1/25 at 3:32 p.m., a note indicated R2 complained of headache and back pain during the shift and was not able to rate pain. R2 was given scheduled pain medications and was somewhat effective. Warm blanket given. Nurse encouraged R2 to get up as R2 was in room and in bed for the past two days, and R2 stated she did not want to get up due to headache. Vital signs were within normal limits. The note indicated staff would continue to monitor and update oncoming shift. During observation and interview on 5/19/25 at 1:10 p.m., R2 laid in bed and stated she had pain in her lower back and migraines. R2 stated she has experienced "very bad" pain for a "long time now", and the pain medications did not help. R2 stated her pain was at an eight or nine out of ten most of the time.	F 697		

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F 697	Continued From page 24 During observation and interview on 5/20/25 at 1:44 p.m., R2 stated the nurse gave her pain medication which would start to work soon. R2 laid in bed and stated she was tired. R2 stated she was not prescribed enough pain pills. During observation and interview on 5/22/25 at 12:09 p.m., R2 laid in bed and stated she was in pain and just received pain medication. R2 rated her pain at an eight and nine and stated her pain was in her lower back, right leg, and had a migraine. R2 stated nurses did not come back to check on her pain after pain medications given. During interview on 5/22/25 at 12:18 p.m., (LPN)-F stated R2 had a lot of different pain medications and had general pain such as back pain. LPN-F stated R2's pain was stable and relieved with current pain interventions, and R2 knew to inform the nurse when she had pain. LPN-F stated they gave scheduled pain medications and then PRN pain medications if resident continued to complain of pain. LPN-F called the provider if PRN pain medications were not effective. LPN-F stated a question popped up in the electronic health record when giving PRN pain medications where nurses indicated assessment of resident's pain, which included pain location and rating, and if the intervention was effective or not. During interview on 5/23/25 at 9:23 a.m., registered nurse (RN)-B stated staff monitored residents' pain every day in their first 100 days of admission and then assessed pain as needed with visual or verbal complaints of pain. RN-B stated R2 did not always give staff a pain rating and would say she "hurts". RN-B stated R2 had chronic back pain, and R2's pain was typically	F 697		

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F 697	Continued From page 25 described as well managed. RN-B reviewed the nursing note from 4/27/25, and stated staff should have followed-up on the comment made by R2 and stated they did not see any follow-up documented. RN-B stated it was important to manage pain for resident's quality of life. During interview on 5/23/25 at 10:00 a.m., the director of nursing (DON) reviewed R2's progress notes and stated staff assessed R2's pain daily. The DON reviewed R2's nursing note from 4/27/25, acknowledged R2's comment, and stated the nurse indicated R2 did not ask for as needed pain medications during the shift. The DON stated R2 and the pharmacist were involved in recent changes of pain medication. The facility provided progress note from 2/21/25 at 9:39 p.m., indicated "Increase med dose: Res [R2] was upset about her Hydromorphone dose. Res stated that she talked to [nurse practitioner; (NP)] yesterday and NP stated that she would increase her Hydromorphone to 2 mg but NP didn't give an order. Res kept requesting to call NP to fix her Hydromorphone dose. Writer called [provider line] and updated about res complaints and NP ordered to change Hydromorphone to 1 mg PO, BID at 0800 and 1600 and Hydromorphone, 2 mg at noon and at 2000 and Hydromorphone, 2 mg, PO, Q4H [every 4 hours], prn." The note indicated R2 was told that her Hydromorphone dose increased and R2 was happy, she received her Hydromorphone 2 mg at bed time, and staff would update the oncoming shift. The facility provided Regulatory Visit note dated 4/11/25, indicated "[R2] continues to [complain of] pain which is a behavioral pattern for her;	F 697		

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F 697	Continued From page 26 subjective descriptions of pain do not really change or improve--even when she sometimes states that previous pain control was better, at that previous time her statements reflected significant pain/not well-controlled; and this pattern repeats. Therefore using more objective measures of pain - she has had less non-verbal pain behaviors with the most recent increase." The facility's Pain Management policy dated 4/28/25, indicated pain management included identifying the characteristics of pain, addressing the underlying causes of pain, developing and implementing approaches to pain management, monitoring for the effectiveness of interventions, and modifying approaches as necessary. The policy indicated nursing staff assessed pain on an ongoing basis and completed pain assessments on admission, quarterly, with change in pain and with change of condition. Reports of pain were handled as high priority and nurses determined which pain scale to use based on many factors. The policy indicated staff followed parameters for as needed pain medication use when more than one as needed pain medication was ordered.	F 697		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet	F 791		7/7/25

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F 791	Continued From page 27 the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a routine dental referral for a missing front tooth was followed up on along with a recommendation for an over-the-counter fluoride rinse to maintain oral health for 1 of 2 residents (R18) reviewed for	F 791	F791 Plan of Correction It is the policy of Cassia to comply with the regulation cited under F791. To assure continued compliance, the following plan has been put into place:	

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F 791	Continued From page 28 dental services. Findings include: R18's quarterly Minimum Data Set (MDS), dated 4/24/25, indicated R18 was admitted to the care facility on 9/20/17, was cognitively intact and required supervision or touching assistance with oral hygiene. R18's most recent dental assessment form by Apple Tree Dental, dated 12/16/24, indicated R18 had "obvious" broken natural teeth and inflamed and bleeding gums. The note indicated R18 required direct staff supervision and if capable, could maintain oral care independently recommending oral care twice daily and to swish twice daily with an over-the-counter fluoride rinse. The Notes to Nursing Staff for follow up section indicated R18 was "self-conscious of missing teeth and would like a dental assessment to repair/replace front teeth." R18's Care Conference Summary, dated 4/29/25, indicated ancillary services, including dental services, were offered to and accepted by R18. The note indicated R18's last dental visit was 4/6/23. R18's care plan, dated 9/21/17, indicated staff were to provide R18 with set up and supervision for cues for dental care. The care planned lacked any interventions related to R18 using an over-the-counter fluoride rinse. R18's Active Orders, printed 5/22/25, lacked any indication R18 was using an over-the-counter fluoride rinse.	F 791	The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: A dental referral was made on 5/18/2025 for R18 to get a broken tooth fixed. Resident asked to be put on the list for the next facility dental visit rather than going out of the facility. R18s care plan was updated to include fluoride rinse per provider recommendations. Actions taken to identify other potential residents having similar occurrences: The Health Information Director completed a review of all residents to identify those needing a follow-up dental visit, a referral made and/or recommendations made during their last dental visit. No other concerns were found during this audit. Measures put in place to ensure deficient practice does not recur: A tracking system will be implemented to monitor dental referrals and recommendations for all residents. Health Information and Social Services received training on the importance of timely follow-up on dental services and recommendations. Effective implementation of actions will be monitored by: Health Information Director and/or designee will audit 100% of resident	

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F 791	Continued From page 29 R18's electronic medical record (EMR) further lacked any indication that the dental referral to repair or replace her front teeth was followed up on. During an interview on 5/19/25 at 2:10 p.m., R18 stated her front tooth had fallen out, and while she did not have pain, she kept her "mouth shut a little more" due to feeling self-conscious of missing a front tooth. During an interview on 5/21/25 at 12:58 p.m., the social services designee (SSD) stated Apple Tree Dental came to the facility approximately every 4-6 months and the Health Information Director (HID) kept a running list of residents who were to be seen at the next dental visit. The SSD reviewed R18 most recent assessment from Apple Tree Dental and confirmed there was a referral for a follow up appointment related to her missing front tooth but was unaware of whether R18 had seen the dentist or had a future referral for dentistry, stating the HID would know that information. During an interview on 5/21/25 at 1:13 p.m., the HID stated R18 had refused dental care in the past so they would only make an appointment for her if she asked. The HID stated he was unaware of any dental issues for R18 and that she was not on his list to be seen by the dentist. During a follow up interview at 1:22 p.m., the HID referred to a dental visit for R18, dated 6/27/22 and two dental refusals dated 1/19/23, 4/6/23, and 10/9/23. The HID reviewed R18's chart, confirming R18 was seen by Apple Tree Dental on 12/16/24, stating he is responsible for reviewing the forms and following up on any recommendations, stating the referral "should	F 791	dental service recommendations monthly for three months to ensure that dental referrals and recommendations are being followed up on. Results of these audits will be reviewed by the facility QAPI committee, and they will make the decision if further monitoring/audits are recommended. The person responsible to maintain compliance is: Health Information Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 791	Continued From page 30 have been followed up on but was not." During an interview on 5/22/25 at 8:28 a.m., the long-term care manager and registered nurse (RN)-B stated the HID was responsible for referring the dental visits/assessments from Apple Tree Dental and passing on any recommendations as needed. RN-B stated she was unaware of the recommendation for R18 to have an over-the-counter fluoride rinse and to have follow up regarding her missing tooth. A facility policy titled Dental Services, reviewed 11/15/24, indicated it was the facility policy to assist residents in obtaining routine and 24-hour emergency dental care.	F 791		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		7/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AUGUSTANA CARE HASTINGS HEALTH AND REHABILITATION	930 WEST 16TH STREET HASTINGS, MN 55033

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F 812	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food temperatures were checked or obtained in a manner to reduce the risk for cross-contamination between food items prepared in the main production kitchen. In addition, the facility failed to ensure 1 of 1 can opener was kept in a clean and sanitary manner. These findings had the potential to affect 66 of 67 residents who consumed food from the main production kitchen. Findings include: Can opener During a visit to the kitchen on 5/19/25 at 6:08 p.m., an Edlund commercial can opener blade's tip had a dark tan dry shinny debris on the tip of the blade up to, black debris caked along most of the blade, reds spots in the upper part of the blade. During observation and interview on 5/20/25 at 8:50 a.m., the commercial can opener blade was still covered with same debris. The culinary director (CD) observed and confirmed the debris built up on the can opener's blade. CD stated the can opener was washed 3 to 4 times a week. CD stated he was not sure when was the last time it was washed. CD stated a dirty blade posed a risk for cross contamination and it should be washed daily. CD added it will add to the evening cleaning duties. Thermometer	F 812	F812 Plan of Correction It is the policy of Cassia to comply with the regulation cited under F812. To assure continued compliance, the following plan has been put into place: The following corrective action will be done for the deficient practice: - The facility immediately retrained kitchen staff on proper food temperature checking procedures and sanitized the can opener to ensure it is maintained in a clean and sanitary manner. Actions taken to identify other potential residents having similar occurrences: - A comprehensive review of all residents consuming food from the kitchen was conducted to ensure no residents were affected by the deficient practice. Measures put in place to ensure deficient practice does not recur: -The facility has implemented a daily checklist for kitchen staff to verify cleanliness of kitchen equipment, including the can opener. - Education was provided to the culinary staff on food safety protocols, specifically proper food temperature process and cleaning the can opener daily. - Staff will receive ongoing training on food safety protocols. Effective implementation of actions will be monitored by:	

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	245224	A. BUILDING _____ B. WING _____	05/23/2025

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F 812	Continued From page 32 During observation and interview on 5/21/25 at 11:45 p.m., cook (Ck)-A checked the temperature of the food ready to be served to the residents. Ck-A used a commercial thermometer to check the temperature of the country fried steak. Ck-A grabbed a moist and stained washcloth next to the sink behind the steam table and proceeded to wipe the thermometer before checking the asparagus temperature. When Ck-A was stopped from checking the next food item's temperature and asked to explain the procedure to clean the thermometer, Ck-A stated he never used alcohol wipes to disinfect the thermometer after checking a food item temperature and before checking the next food item on the steam table. Ck-A stated he would get a clean washcloth to prevent cross contamination. During interview on 5/21/25 at 1:44 p.m., CD stated using a moist dirty washcloth was not the facility's procedure to disinfect the thermometer. CD stated the thermometer used to check the food temperature should be sanitized with an alcohol wipe or a sanitizing solution to prevent cross contamination. During interview on 5/22/25 at 1:07 pm., director of nursing stated a dirty can opener and failure to use proper sanitization procedure of a thermometer used to temp the food were infection control issues. Facility's policy titled Sanitation dated 1/10/25, indicated food service areas shall be maintained in a clean and sanitary manner. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means	F 812	- The facility's Culinary Director and/or designee will audit compliance with food temperature process and equipment sanitation 3 x week x 1 month, then weekly x 2 months for compliance. Results of these audits will be reviewed by the facility QAPI committee, which will decide if further monitoring/audits are recommended. The person responsible to maintain compliance is: Culinary Director	

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F 812	Continued From page 33 necessary and sanitized using hot water and/or chemical sanitizing solutions. Facility's policy title Food Temperature Monitoring dated 1/5/22, indicated during temperature monitoring, thermometers should be sanitized prior to checking food temperatures, and between each food item. You may use an alcohol swap or sanitizing solution.	F 812		
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 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		7/7/25

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F 880	Continued From page 34 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 35 Based on observation, interview, and document review, the facility failed to ensure personal protective equipment (PPE) was removed and hand hygiene completed prior to room exit for 2 of 2 residents (R6 and R28) observed for enhanced barrier precautions (EBP). In addition, the facility failed to ensure housekeeping staff changed their gloves and performed hand hygiene between cleaning of two resident (R2 and R27) rooms. As well, the facility failed to follow infection control practices while assisting with resident eating to reduce the risk for the spread of infection for 3 of 8 residents (R3, R28, R32) reviewed who required staff assistance with dining. Findings include: ENHANCED BARRIER PRECAUTIONS R6's annual Minimum Data Set (MDS) dated 4/3/25, indicated R6 had intact cognition and a diagnosis of diabetes mellitus. In addition, R6 had a stage four pressure ulcer and required substantial and/or maximal assistance to roll left and right and was dependent on staff for transfers. R6's physician order dated 4/3/25, indicated treatment orders for R6's sacral wound once daily. R6's EBP care plan revised 3/28/25, indicated R6 required EBP for impaired skin integrity and directed staff to follow EBP per policy. R28's quarterly MDS dated 4/10/25, indicated R28 had moderately impaired cognition, and diagnoses of heart failure, other fracture, anxiety disorder and depression. In addition, R28 had an	F 880	F880 Plan of Correction It is the policy of Cassia to comply with the regulation cited under F880. To assure continued compliance, the following plan has been put into place: " The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: o Staff involved in the incidents with residents R6, R28, R2, R27, R3, and R32 have been re-educated on proper PPE removal, hand hygiene, and infection control practices. Immediate retraining sessions were conducted to ensure understanding and compliance. " Actions taken to identify other potential residents having similar occurrences: o A facility-wide audit was conducted to observe and ensure compliance with PPE removal, hand hygiene, and infection control practices for all residents. Any staff observed not following protocols were immediately corrected and re-educated. " Measures put in place to ensure deficient practice does not recur: o Nursing staff were educated on proper donning and doffing of PPE in addition to proper hand hygiene prior to leaving resident rooms. o Housekeeping staff were educated that prior to leaving a room post cleaning; their gloves are to be removed, and proper hand hygiene is to be completed. o Nursing staff educated on proper hand hygiene while assisting residents during mealtimes. Staff were educated regarding the hand hygiene policy which	

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F 880	Continued From page 36 indwelling catheter and was dependent on staff for activities of daily living. R28's physician orders dated 1/30/25, indicated "Catheter type: Coude Fr. (French) 16; Balloon size: 10 cc (cubic centimeters); Frequency catheter changes every 4 hours PRN (as needed) for by passing or if clogged/falls out". R28's EBP care plan revised 4/16/25, indicated R28 required EBP related to an indwelling catheter and directed staff to follow EBP per policy. During observation on 5/20/25 at 2:04 p.m., NA-C exited R28's room and wore a gown and gloves. NA-C pushed a mechanical lift down the hallway to a section where another mechanical transfer device was stored. NA-C cleaned the lift and still wore the same gown and gloves. NA-C removed their PPE, threw the PPE in a soiled utility room, and completed hand hygiene. During interview on 5/20/25 at 2:07 p.m., NA-C stated they assisted another staff member to transfer R28 into bed. NA-C stated they should have removed their PPE upon exiting R28's room, but kept the PPE on because the wipes to clean the lifts had bleach in them. During observation on 5/21/25 at 9:35 a.m., NA-D wore a gown and gloves and took R6's toothbrush and basin from her and rinsed them in the bathroom. NA-D removed gloves, performed hand hygiene (HH), and assisted R6 to turn side to side to get a sling underneath her. NA-D removed the gown as exiting R6's room and held the gown in their hand as they went to the full mechanical lift, which was more than four feet	F 880	states hand washing and hand sanitizing with an alcohol-based hand sanitizer (ABHS) agent may be used interchangeably. Hand washing/sanitizing is necessary: After each resident contact. " Effective implementation of actions will be monitored by: o The Infection Control Nurse will audit 20% of resident care episodes weekly for three months to ensure proper PPE removal, hand hygiene, and infection control practices are followed. Results of these audits will be reviewed by the facility QAPI committee, and they will make the decision if further monitoring/audits are recommended. " The person responsible to maintain compliance is: o The facility's Infection Control Nurse.	

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F 880	Continued From page 37 away from the resident's room and across the hallway. Licensed practical nurse (LPN)-B nurse directed NA-D to place the gown in the hamper in R6's room. NA-D returned to R6's room with the lift and previously worn gown in hand and placed the gown in the hamper in R6's room. NA-D placed on a new gown, completed hand hygiene, and applied gloves. During interview on 5/21/25 at 10:04 a.m., NA-D stated they were supposed to remove PPE inside R6's room and prior to room exit. During interview on 5/21/25 at 2:03 p.m., LPN-B verified they gave NA-D correction in the moment and stated staff should remove PPE prior to room exit and not carry PPE down the hallway. During interview on 5/22/25 at 11:57 a.m., registered nurse (RN)-B stated staff needed to remove their gown and gloves and complete hand hygiene before leaving a room with enhanced barrier precautions for infection control purposes. During interview on 5/22/25 at 1:34 p.m. with the director of nursing (DON) present, the infection preventionist (IP) stated staff needed to remove their gowns and gloves before they left a resident room under enhanced barrier precautions. IP stated there was a risk of spreading infection when PPE was not removed prior to room exit. The facility policy Transmission-based precautions, enhanced barrier precautions and empiric precautions dated 5/13/25, directed staff to don gown and gloves prior to high-contact care activity and change PPE before caring for another resident for a resident under enhanced barrier	F 880		

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F 880	Continued From page 38 precautions. The policy directed staff to doff gown and gloves before room exit for a resident under contact precautions and did not specific PPE removal for a resident under enhanced barrier precautions. HOUSEKEEPING R2's quarterly MDS dated 3/13/25, indicated R2 had intact cognition and diagnoses of seizure disorder or epilepsy, depression, and psychotic disorder. In addition, R2 was independent with most activities of daily living. R27's significant change MDS dated 4/24/25, indicated R27 had intact cognition and their activities of daily living needs varied from independent to substantial and/or maximal assistance. During observation on 5/21/25 at 9:57 a.m., housekeeping aid (HA)-A wore gloves, exited R27's room, took a mop head off the mop handle, and placed the mop head in a plastic bag. HA-A wore the same gloves, removed the broom and dustpan from the housekeeping cart, and swept near the entrance of R27's room. HA-A wore the same gloves, placed the broom and dustpan back on the cart, and placed a wet floor sign in R27's room. HA-A wore the same gloves, knocked on R2's door, entered R2's room, and turned on the bathroom sink. Another housekeeping aid came to clean the bathroom. HA-A wore the same gloves and wiped furniture surfaces near the window in R2's room. HA-A wore the same gloves, mopped R2's floor, and used the broom and dustpan near R2's room entrance.	F 880		

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F 880	Continued From page 39 During interview on 5/21/25 at 10:09 a.m., HA-A verified they did not change their gloves or complete hand hygiene between R2 and R27's room. HA-A stated they should change their gloves and complete hand hygiene after every room and before cleaning the bedroom if they cleaned the bathroom first. During interview on 5/21/25 at 11:21 a.m., the director of environmental services (ESD) expected staff to change their gloves and perform hand hygiene between resident rooms to prevent cross contamination. During interview on 5/22/25 at 1:34 p.m. with the director of nursing (DON) present, IP expected housekeeping staff to change their gloves and complete hand hygiene between residents' rooms and upon exit of room to go to the housekeeping cart. IP stated staff were at risk of spreading germs. The facility policy Hand Hygiene dated 7/3/24, directed staff to perform hand hygiene after touching environmental surfaces. DINING R3's Resident Profile dated 5/21/25, indicated R3 required extensive assistance from staff while eating. R28's Resident Profile dated 5/20/25, indicated R28 required extensive assistance from staff while eating. During an observation on 5/21/25 at 8:15 a.m., nursing assistant (NA)-A was observed sitting	F 880		

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F 880	Continued From page 40 with R28 to her left and R3 to her right. NA-A was observed to use her right hand to take a spoon of food to R28's mouth, put the spoon down, and then use R28's clothing protector to wipe R28's mouth. NA-A then used her right hand to take a spoon of food to R3's mouth and used R3's clothing protector to wipe her mouth. NA-A then used her right hand to adjust the top of R3's straw to assist R3 with drinking. NA-A then began assisting R28 with eating with her right hand and continued the same process as outlined above. At 8:33 a.m., NA-A was observed to take a pen out of her pocket and write something down. NA-A then put the pen back in her pocket, grabbed R3's straw with her right hand, and adjusted it to give R3 another drink before removing her clothing protector. NA-A was observed to then leave the table. During this observation, hand hygiene was not observed to be completed by NA-A. During an interview on 5/21/25 at 11:07 a.m., NA-A stated she had received training on how to assist residents with eating from the facility. NA-A stated she was supposed to complete hand hygiene before and after assisting residents with eating and make sure each hand was only used to assist one resident. During observation on 5/21/25 at 12:41 p.m., NA-C assisted R3 and R28 with dining. NA-C primarily used one hand to alternate between R3 and R28 with meal assistance and did not perform hand hygiene between the residents. NA-C wiped R28's mouth with a clothing protector and continued with meal assistance for both residents without hand hygiene between the residents.	F 880		

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F 880	Continued From page 41 During interview on 5/21/25 at 2:17 p.m., NA-C stated they completed hand hygiene before meal assistance and verified they did not complete hand hygiene between resident assistance. NA-C stated they were right-handed and was not sure if they should use both hands to assist two residents at the same time with their meals. During interview on 5/22/25 at 11:57 a.m., RN-B stated staff needed to complete hand hygiene between residents during meal assistance or should designate one hand to each resident. During interview on 5/22/25 at 1:34 p.m. with the director of nursing (DON) present, IP stated staff needed to perform hand hygiene between assistance of residents in the dining area due to infection risk. R32 R32's annual Minimal Data Set (MDS) dated 5/8/25, indicated was cognitively impaired, needed maximal assistance with eating, oral hygiene, showers, upper body dressing, personal hygiene and was dependent on staff with lower body dressing, toileting hygiene and transfers. R32 also included diagnoses of dementia, non-traumatic brain dysfunction, diabetes mellitus, arthritis and anxiety disorder. R32's eating care plan printed 5/22/25, indicated R32 required extensive assistance of one staff to eat meals due to weakness and dementia. During observation on 5/19/25 at 6:00 p.m., dinner was served in the second-floor dining room. The dinner consisted of a pulled pork sandwich, tater tots, mixed greens salad and	F 880		

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F 880	Continued From page 42 mandarin oranges gelatin. Some of the residents did not require any assistance, some needed help to set up their meals, and others required maximal assistance to eat their meals. During observation on 5/19/25 at 6:21 p.m., R32 was sitting with 5 other residents who required moderate to maximal assistance to eat. Nursing assistant (NA)-F was sitting between R32 and another resident who required maximal assistance to eat. At 6:38 p.m. NA-F held R32's sandwich in his hand, talked to her, and brought the sandwich to 32's mouth and she took a bite. NA-F used a fork to give a bite to the resident sitting on his right side without hand hygiene. A couple minutes later, NA-F grabbed a tater tot with his hand but R32 didn't eat it. NA-F held R32's sandwich in his hand and offered to R32 but she turned her head away. During interview on 5/21/25 at 1:53 p.m., NA-F stated on 5/19/25, as usual, he used hand sanitizer before he started to help R32 and another resident to eat their dinner. NA-F stated both residents needed maximal assistance and R32 used special silverware. NA-F said sometimes R32 had trouble holding the silverware and needed maximal assistance to eat, and sometimes R32 could not focus and it was easier to for NA-F to hold the food with his hand to bring the food very close to R32's mouth. NA-F stated sometimes R32 needed to take a first bite and appeared to remember she was eating. NA-F acknowledged he was helping R32 and another resident to eat dinner, and acknowledged he held a tater tot and the sandwich with his hands. NA-F stated it was wrong to hold R32's food with his hands because it was a break of the infection control practice.	F 880		

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F 880	Continued From page 43 During interview on 05/22/25 at 01:07 p.m., director of nursing stated using one's bare hands to help R32 to eat was an infection control issue. The facility's Feeding of Residents by Staff policy dated 3/10/25, indicated staff were to perform hand hygiene before and after assisting residents with eating but did not outline the procedure when staff were assisting more than one resident at a time to eat. In addition, the policy indicated residents unable to feed themselves will be provided with assistance per their care plan. The policy indicated to offer small bite-sized portions on the fork or spoon at a regular rate.	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245224	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CARE HASTINGS HEALTH AND REHABILITATION	**930 WEST 16TH STREET** **HASTINGS, MN 55033**

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

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

Electronically Signed | 06/18/2025

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. Building Info: Augustana Health Care Center of Hasptins is a 2 story building with a partial basement. The Building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II (111 construction. In 1973 and 1992, additions were added to the building that ws determined to be Type II (111) construction. Because the origianl building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as	K 000		

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K 000	Continued From page 2 one building. The facility has a capacity of 72 beds and had a census of 65 at the time of the survey.	K 000		
K 200 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview the facility was not following the applicable NFPA 101 and NFPA 80, 5.2.3.5.2, for testing and inspecting of the facility fire doors. This deficient finding could have a widespread impact on the residents. Findings include: On 05/20/2025, at 9:43 AM, by review of the available documentation at the time of the survey, there was no fire door inspection report available for review.	K 200	K200 It is the policy of Cassia to comply with the regulation cited under K200. To assure continued compliance, the following plan has been put into place: The following corrective action will be done to correct the deficiency: The annual fire door inspection was completed by Maintenance Technician on 6/18/25. All fire-rated doors in the facility were inspected to ensure they meet NFPA 101 standards. Measures put in place to ensure deficient	7/7/25

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K 200	Continued From page 3 An interview with the Maintenance Director verified this deficient finding.	K 200	practice does not recur: The facilitys preventative maintenance schedule has been updated to include a recurring annual task for fire door inspections, with a due date alert system to ensure timely completion. Maintenance staff were educated on the importance of fire door compliance and the specific requirements of NFPA 101 and NFPA 80. The facility will monitor the effectiveness of the implementation by: A member of the maintenance team will report the status of annual fire door inspections to the facility's monthly Quality Assurance and Performance Improvement (QAPI) meeting for 3 months to ensure compliance. Compliance will also be verified during monthly safety meetings. Any issues will be addressed immediately and corrective actions documented. The person responsible for the corrective actions and monitoring of compliance is: Maintenance Director	
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the	K 222		7/7/25

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K 222	Continued From page 4 clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.	K 222		

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K 222	Continued From page 5 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the proper operation of exit door locking device system per NFPA 101 (2012 edition), Life Safety Code, section 7.2.1.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/20/2025 at 10:30 AM, it was revealed by observation the Laundry Stairwell door on the first floor failed to latch when tested. An interview with Maintenance Director verified this deficient finding at the time of discovery	K 222	K222 Brief description of corrective action or planned corrective action: The facility immediately inspected and repaired the exit door locking device system to ensure proper operation in compliance with NFPA 101 (2012 edition), Life Safety Code, section 7.2.1.6.1.1. Steps to prevent recurrence: Conduct regular inspections of all exit door locking devices to ensure they are functioning correctly. Train staff on the importance of reporting any malfunctioning exit door locking devices immediately. Implement a routine maintenance schedule for all exit door locking systems. How the facility plans to monitor future performance to ensure solutions are sustained: Monthly audits of exit door locking devices will be conducted by the maintenance team. Results of audits will be reviewed in monthly safety meetings to ensure ongoing compliance and address any issues promptly.	

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K 222	Continued From page 6	K 222	Person responsible for compliance: Maintenance Supervisor	
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 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 commercial cooking equipment per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3, NFPA 96 (2011 edition), Standard for Ventilation Control and Fire	K 324	K324 - Plan of Correction It is the policy of Cassia to comply with the regulation cited under K324. To assure continued compliance, the following plan has been put into place:	7/7/25

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K 324	Continued From page 7 Protection of Commercial Cooking Operations, section 10.2.6, and NFPA 17A (2009 edition), Wet Chemical Extinguishing Systems, section 4.3.1.5. This deficient finding could have a widespread impact on residents within the facility. Findings include: On 05/20/2025, at 10:48 AM, it was revealed by observation that the baffle filters within the Kitchen hood were not positioned to prevent grease from entering the hood system. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	The following corrective action will be done to correct the deficiency: The facility immediately contacted a certified technician to inspect and service the kitchen hood to ensure compliance with NFPA 101, NFPA 96 and NFPA 17A standards. The baffle filters were repaired at that time. Measures put in place to ensure deficient practice does not recur: The maintenance staff were in-serviced on 6/17/2025 regarding the proper placement and function of baffle filters per NFPA 101 requirements. A visual inspection of the baffle filter placement has been added to the monthly kitchen hood inspection checklist. The facility will monitor the effectiveness of the implementation by: The Maintenance Director will perform and document monthly inspections of the kitchen hood system for proper baffle filter placement and cleanliness. Inspection results will be reviewed during the facility's monthly Quality Assurance and Performance Improvement (QAPI) meeting for three months. Any deviations will be corrected immediately, and retraining provided as necessary. The person responsible for the corrective actions and monitoring of compliance is: Maintenance Director	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING	K 351		7/7/25

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K 351	Continued From page 8 Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/20/2025, at 9:56 AM, it was revealed by observation that there were wires in contact with the sprinkler system above the ceiling at the entrance to the long hallway. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 351	K351 Plan of Correction It is the policy of Cassia to comply with the regulation cited under K351. To assure continued compliance, the following plan has been put into place: The following corrective action was be done to correct the deficiency: On 6/10/2025, the identified wires were immediately removed from the sprinkler pipe by the facility's maintenance department to eliminate any potential compromise to the sprinkler system. Measures put in place to ensure deficient practice does not recur: A full inspection of the facility was completed on 6/18/2025 to identify any other instances where wires or non-sprinkler items were resting on or attached to sprinkler piping. No additional violations were identified.	

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K 351	Continued From page 9	K 351	The facility's maintenance protocols now require all contractors to check in with the maintenance department at both the beginning and end of each project. This ensures maintenance staff can visually inspect the work areas to identify and address any potential concerns related to NFPA compliance. All maintenance staff were educated on 6/17/2025 regarding the requirements of NFPA 13 related to sprinkler systems, specifically the prohibition of using sprinkler piping to support other systems and/or allowing any wires to be in contact with the sprinkler system. The facility will monitor the effectiveness of the implementation by: The Maintenance Supervisor or designee will conduct monthly audits for three months to ensure compliance. Any findings will be addressed immediately, and results will be reported at the facility's monthly QAPI Committee meeting. Continued compliance will be monitored on an ongoing basis thereafter. The person responsible for the corrective actions and monitoring of compliance is: The Maintenance Director	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no	K 511		7/7/25

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K 511	Continued From page 10 hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Gas and Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.2.2 and NFPA 54 (2012 edition), National Fuel Gas Code, sections 9.2.2 and 10.3.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/20/2025, at 10:33 AM, it was revealed by observation that the electrical panels located in the tunnel outside of the Maintenance Shop was not secured. Additionally, there was exposed electrical elements in the Laundry Mechanical Room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	K511 It is the policy of Cassia to comply with the regulation cited under K511. To assure continued compliance, the following plan has been put into place: Brief description of corrective action or planned corrective action: The facility immediately secured all electrical panels according to the NFPA 99 (2012 edition) and NFPA 101 (2012 edition) standards. The maintenance team fixed the exposed wires in the laundry mechanical room so they were no longer exposed. Steps to prevent recurrence: Conduct regular inspections of all electrical panels to ensure they remain secure and compliant. Conduct regular inspections of areas that have the potential to have exposed wires. Train staff on the importance of maintaining secure electrical panels and ensuring wires are not exposed, emphasizing the potential risks of non-compliance. Implement a checklist for maintenance staff to verify the security and compliance of electrical systems and verification of no exposed wires during routine checks. The checklists will be placed in the maintenance tracking system to ensure a	

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K 511	Continued From page 11	K 511	routine inspection is completed. How the facility plans to monitor future performance to ensure solutions are sustained: Monthly audits will be conducted by the maintenance team to ensure all electrical panels remain secure and compliant. Quarterly reviews will be held to assess the effectiveness of the training and inspection processes. Any identified issues will be addressed immediately, and findings will be reported to the facility's safety committee and QAPI team for further action. Person responsible for compliance: The Maintenance Supervisor	
K 712 SS=D	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 under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This	K 712	K712 Brief description of corrective action or planned corrective action: The facility will immediately conduct fire drills at varied times and under different	7/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245224	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CARE HASTINGS HEALTH AND REHABILITATION	**930 WEST 16TH STREET HASTINGS, MN 55033**

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K 712	Continued From page 12 deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/20/2025, at 9:20 AM, it was revealed by a review of available documentation that the facility had exceeded the allowable 3 months between fire drills 2 time in 2024. An interview with the Mainteance Director verified this deficient finding at the time of discovery.	K 712	conditions to ensure compliance with NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6, 4.7.4, and 4.6.1.1. Steps to prevent recurrence: Schedule fire drills at random times and under diverse conditions, including during different shifts and weather conditions. Train staff on the importance of conducting fire drills under varied circumstances to ensure preparedness. Implement a tracking system to document the timing and conditions of each fire drill conducted. How the facility plans to monitor future performance to ensure solutions are sustained: The facility will conduct monthly audits of fire drill logs to ensure drills are conducted at varied times and conditions. Results will be reviewed in monthly safety committee and QAPI meetings and to ensure ongoing compliance. Person responsible for compliance: The Maintenance Director is responsible for maintaining compliance with fire drill requirements.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are	K 914		7/7/25

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	245224	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/20/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CARE HASTINGS HEALTH AND REHABILITATION	**930 WEST 16TH STREET HASTINGS, MN 55033**

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K 914	Continued From page 13 tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct annual electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/20/2025, at 9:45 AM, it was revealed by a review of available documentation that the annual electrical outlet inspection had not been completed within the last year. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	K914 Brief description of corrective action or planned corrective action: The facility has scheduled immediate testing of all electrical receptacles in resident rooms to ensure compliance with NFPA 99 (2012 edition) standards. This testing will be completed by a certified electrician. Steps to prevent recurrence: Establish a recurring annual schedule for electrical receptacle testing in all resident rooms. Train maintenance staff to recognize and report any issues with electrical receptacles promptly. Maintain a log of all testing activities, including dates and results, to ensure accountability and traceability. How the facility plans to monitor future performance to ensure solutions are sustained: The facility will conduct quarterly audits of	

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	245224	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/20/2025**

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K 914	Continued From page 14	K 914	the electrical receptacle testing log to verify that all scheduled tests are completed on time. Any discrepancies will be addressed immediately to prevent future lapses. Person responsible for compliance: The Maintenance Supervisor will be responsible for ensuring compliance with the annual electrical receptacle testing requirements.	