



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 12, 2025

Administrator
First Care Living Center
900 HILLIGOSS BOULEVARD SOUTHEAST
FOSSTON, MN 56542

RE: CCN: 245512

Cycle Start Date: July 30, 2025

Dear Administrator:

On September 4, 2025, the Minnesota Department of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



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December 12, 2025

Administrator

First Care Living Center

900 HILLIGOSS BOULEVARD SOUTHEAST
FOSSTON, MN 56542

Re: Reinspection Results
Event ID: WA3T11-H2

Dear Administrator:

On September 4, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 30, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 15, 2025

Administrator

First Care Living Center

900 HILLIGOSS BOULEVARD SOUTHEAST
FOSSTON, MN 56542

RE: CCN:245512

Cycle Start Date: July 30, 2025

Dear Administrator:

On July 30, 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:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 October 30, 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 January 30, 2026, (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,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245512		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER First Care Living Center				STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST , FOSSTON, Minnesota, 56542			
(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	
E0000	Initial Comments On 7/28/25 through 7/30/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			08/18/2025	
F0000	INITIAL COMMENTS On 7/28/25 through 7/30/25, 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.		F0000			08/18/2025	
F0637 SS = D	Comprehensive Assessment After Signficant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not		F0637	Status of resident (R2) reviewed by IDT and determined significant change MDS is warranted. Therapy, dietician, and provider were consulted. A significant change MDS opened with an ARD on 8/4/2025. All residents were reviewed to see if any residents' conditions meet criteria for significant changes. Observations were opened on any resident who may meet significant changes criteria.		08/10/2025	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0637 SS = D	Continued from page 1 normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to complete a significant change in status assessment (SCSA) when two or more areas of change in resident status were identified on the Minimum Data Set (MDS) for 1 of 5 residents (R2) reviewed for activities of daily living (ADLs). Findings include: R2's quarterly MDS dated 4/2/25, identified R2 had severe cognitive impairment. R2 was independent with eating and could turn and reposition herself in bed. R2 required moderate assistance to sit up, toilet, transfers and ambulate 10 feet, 50 feet and 150 feet. Diagnoses included malignant neoplasm of breasts, dementia and low back pain. R2's quarterly MDS dated 7/2/25, identified R2 had severe cognitive impairment. R2 required set up with eating and moderate assistance to turn and reposition when in bed. R2 required maximum assistance to sit up, toilet, transfers and ambulation 10 feet. Ambulation 50 and 150 feet were not attempted due to medical condition or safety concerns. R2's care plan with review date 6/27/25, identified R2 required assistance with activities of daily living (ADLs) and was at risk for needing more assistance due to changing cognitive ability. Staff were instructed to use extensive assist of two or three persons to ambulate, and R2 was independent with bed mobility. R2 needed moderate to maximum assistance with dressing and extensive assist of one to two persons with transfers and toileting. R2's care plan had not been updated to reflect her more current functional assessments and decline in physical mobility. R2's Functional Abilities Assessment dated 7/3/25, identified R2 required setup with eating and assist of one with toileting, grooming, bed mobility, toileting, transfers, and dressing. R2 was having more difficulty with ambulation, dependent with ambulation up to 10 feet and was unable to ambulate any further. R2's progress notes were reviewed 6/1/25 through 7/27/25 and identified the following; -6/4/25, identified staff had concerns with R2's ambulation, needing two persons to ambulate and another with the wheelchair behind as R2 tilted badly to the side with ambulating. R2 was requiring a stand lift to transfer more in the evenings. -6/4/25, an order was obtained for a physical therapy evaluation and treatment for	F0637	Continued from page 1 All staff were educated on what constitutes a significant change in a resident's condition. Nursing educated on notification to provider and documentation of changes in condition. RNs & MDS staff reviewed Significant Change criteria in RAI manual. Significant change worksheet, prepared by MDS Consultants, distributed to staff and placed in daily huddle binder for reference. Daily huddle will include a review of all resident changes by the IDT. A section was added to the daily huddle sheet to record all residents with changes to observe and determine if changes meet criteria for a significant change MDS as outline per the RAI manual. Resident weights will be reviewed weekly to identify residents who are nearing the threshold for weight gain or loss over the last 30, 90 or 180 days. Interventions will be implemented and care plans updated when needs/changes are identified, and significant change assessments will be completed as necessary. Will audit 25% of the resident records monthly and as needed to determine if significant changes in resident status have been identified and documented appropriately, including provider notifications, care plan interventions added, and significant change MDS assessment is completed. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed.	

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F0637 SS = D	Continued from page 2 ambulation and transfers. -6/5/25, staff identified R2 needed a lot of encouragement with ambulation. R2 would take shuffling her feet, knees rubbing against each other, taking a bit of time to take a step and then suddenly R2's knees would buckle, and she would start to drop. -6/26/25, a significant weight loss was identified, as R2 had lost 8 pounds, 5 percent, in 28 days. During interview on 7/29/25, at 2:40 p.m. trained medical assistant (TMA)-B stated R2 used to ambulate but did not now. R2 would lean heavily to one side, and it just was not safe for her to ambulate. R2 was still able to stand and pivot most of the time. TMA-B was not sure if therapy worked with R2 after she stopped ambulating. TMA-B did not think anything specific had occurred, and thought it was related to a decline in her general condition. During observation on 7/29/25, at 6:29 p.m., nursing assistant (NA)-A was assisting R2 to wash and dry and put on a nightgown, NA-A put a gait belt around R2's waist and instructed her to grab on to the grab bar and stand. NA-A assisted R2 to a standing position and finished peri care and put on a disposable brief. NA-A assisted R2 to pivot and sit in her wheelchair. R2 was able to bear weight but unable to take a full step to pivot and became unsteady, with knees knocking together. NA-A assisted R2 to sit down in the wheelchair quickly due to R2 becoming off balance. NA-A stated R2 used to walk but was no longer able to. R2 usually could transfer with one person but occasionally would need two and the stand lift. When interviewed on 7/30/25, at 8:29 a.m. registered nurse (RN)-A stated she completed the MDS's for the residents in the facility. She considered a significant change with residents when they returned from the hospital and there were changes with the resident's abilities, as well as when the facility nurses or nursing assistants reported changes or a decline noted with residents. When a resident needed more assistance with ADLs, had memory changes or wound with delayed healing a significant change MDS would be needed. There had been an order for therapy to see R2 and she had not realized that was not completed yet. They should have seen her to evaluate the decline in physical mobility. She should have followed up with therapy and that had gotten missed. Therapy usually was good about communicating with nursing staff and nursing should have followed up with them to ensure the assessment had been completed as that would have helped them to trigger R2 was a significant change as well. RN-A stated she knew R2 was having some cognitive issues as well. Further, RN-A stated she should have done a significant change instead of her last quarterly or		F0637				

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F0637 SS = D	Continued from page 3 documented why she felt one was not required, if she felt was more of an acute change and was not anticipated to be a permanent decline. During interview on 7/30/25, at 1:35 p.m. the director of nursing (DON) stated R2 should have had a significant change MDS completed instead of a quarterly due to the decline in her physical abilities. The Centers for Medicaid and Medicare Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual pages 2-21 through 2-28 identified a significant change in assessment (SCSA) was appropriate if there were two or more changes in the following areas: decision making ability, presence of a mood item not previously recorded, changes in frequency or severity of behaviors, any decline in an ADL physical functioning area where a resident was newly coded as moderate, maximum assistance, dependent or activity not attempted since last assessment, incontinence pattern changes, placement of indwelling catheter, or the emergence of unplanned weight loss of 5% in 30 days or 10% in 180 days, emergence of a new pressure ulcer stage two or higher, or use of a new restraint. The facility policy Notification of Condition dated 7/5/24, identified the nurse would update the resident's care plan, communicate the changes to the rest of the care team and the interdisciplinary team would review the resident with changes in condition to determine if a significant change MDS was needed based on the resident assessment instrument guidelines.		F0637				
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the		F0657	Resident (R15) care plan was reviewed and updated with her current abilities. An audit was conducted of all resident care plans and any discrepancies found were corrected, and care plans were updated accordingly. Care plan standard work reviewed and updated. Care plans will be reviewed at a minimum quarterly and as needed with changes. EHR widget will be utilized for goals and interventions nearing their end date to be reviewed and updated. Licensed staff received education on requirements to review and update care plans, when appropriate due to changes in ability, condition, physician orders, falls, infections, medical events, medication changes, etc. All staff were educated on process to follow when functional changes occur that could have an impact on the care plan goals or interventions. Will audit 25% of the resident care plans monthly and as needed. Results of these audits will be reviewed by the QAPI committee who will determine a plan for		08/10/2025	

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F0657 SS = D	Continued from page 4 resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to revise the care plan to remove restorative nursing ambulation program from the care plan for 1 of 4 resident (R15) reviewed for restorative nurse services. Findings include: R15's quarterly Minimum Data Set (MDS) dated 6/4/25, identified R15 had severe cognitive impairment and identified R15 was dependent of staff for transfers and bed mobility and R15 did not ambulate (walk). R15's care plan dated 6/3/25 identified:R15 was to ambulate with an assist of two of the restorative aides assisting, until physical therapy (PT) provided further treatment.R15 was on a wellness ambulation program that indicated R15 would ambulate daily or as tolerated with restorative.R15's doctor's note from 11/14/24, identified R15 had declined and was no longer able to walk. R15 behavioral health note from 12/31/24, identified resident was no longer ambulating. During an interview on 7/29/25 at 2:12 p.m., family member (FM)-A stated R15 had not walked for close to a year. During interview on 7/30/25 at 8:21 a.m., trained medication assistant (TMA)-C stated they had been working here for a couple of years and had not seen R15 walk. During interview on 7/30/25 at 9:00 a.m., TMA-A (who also work as a restorative aide) stated R15 was able to stand and transferred from bed to wheelchair. R15 had not been able to walk and was not receiving ambulation		F0657	Continued from page 4 ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed.			

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F0657 SS = D	Continued from page 5 services. During interview on 7/30/25 at 12:30 p.m., registered nurse (RN)-B stated at one time R15 was able to walk but it was a long time ago. The care plan should have been updated when there was a change in R15's walking abilities. During interview on 7/30/25 at 12:37 p.m., RN-C stated R15 had not been ambulatory since they were in their current position, which was about a year. Care plans were to be reviewed every three months, or if there was a change in a resident's status. R15 was not ambulating, and the care plan should have reflected that. During interview on 7/30/25 at 12:41 p.m., the director of nursing (DON) stated it was an expectation a resident's care plan was to be reviewed every three months or sooner if there had been a change in a resident's status. R15 was not ambulatory, and the care plan should have been updated. The facility's Care Planning-Care Conferences policy dated 8/9/24, identified to reviewed and updated plan of care quarterly and with any change in resident condition or care needs.		F0657				
F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:		F0676	Per interviews with therapy staff, therapy had made multiple attempts to assess R2, who refused. Therapy states these attempts were not documented in the resident's record. Therapy was able to successfully perform their assessment of R2 on 7/30/25. All resident charts with active therapy orders were reviewed to determine if evaluations were completed and treatments received as indicated. Therapy was notified of any incomplete evaluations. Therapy completed evaluations or documented the reason for the delay on any incomplete evaluations. Therapy process reviewed. Form created and will be reviewed in the daily huddle to track therapy orders and when evaluations will be completed. Staff were educated on importance of thorough documentation, follow-ups, and provider notification. Staff were also educated on the updated process as follows. For newly admitted residents, if the therapy evaluation is not completed within 24 hours, nursing will contact therapy for an estimated completion date. For non-Medicare stays, nursing will contact therapy if the evaluation is not completed within 3 business days. Therapy will document attempts in the resident's record and will document reasoning if they are unable to complete the		08/01/2025	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F0676 SS = D	Continued from page 6 §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess for a decline in activities in daily living (ADL) and ensure a referral from physical therapy for the decline in ADL's was acted upon for for 1 of 5 residents (R2) reviewed for ADL's Findings include: R2's quarterly Minimum Data Set (MDS) dated 4/2/25, identified R2 had severe cognitive impairment. R2 was independent with eating and could turn and reposition herself in bed. R2 required moderate assistance to sit up, toilet, transfers and ambulate 10 feet, 50 feet and 150 feet. Diagnoses included malignant neoplasm of breasts, dementia, atrial fibrillation (irregular heartbeat) and low back pain. R2's quarterly MDS dated 7/2/25, identified severe cognitive impairment. R2 required set up with eating and moderate assistance to turn and reposition when in bed. R2 required maximum assistance to sit up, toilet, transfers and ambulation 10 feet. Ambulation 50 and 150 feet were not attempted due to medical condition or safety concerns. R2's care plan with review date 6/27/25, identified R2		F0676	Continued from page 6 evaluation. Nursing will document their contact with therapy and the notification to the physician if a therapy evaluation is delayed. Audits of therapy orders and evaluations will be conducted weekly times 4 weeks, then monthly and as needed. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed.			

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F0676 SS = D	Continued from page 7 required assistance with activities of daily living (ADLs) and was at risk for needing more assistance due to changing cognitive ability. Staff were instructed to use extensive assist of two or three persons to ambulate, and R2 was independent with bed mobility. R2 needed moderate to maximum assistance with dressing and extensive assist of one to two persons with transfers and toileting. R2's care plan had not been updated to reflect her more current functional assessments and decline in physical mobility. R2's progress notes were reviewed 6/1/25 through 7/27/25 and identified the following;6/4/25, identified staff had concerns with R2's ambulation, needing two persons to ambulate and another with the wheelchair behind as R2 tilted badly to the side with ambulating. R2 was requiring a stand lift to transfer more in the evenings. 6/4/25, an order was obtained for a physical therapy evaluation and treatment for ambulation and transfers. 6/5/25, staff identified R2 needed a lot of encouragement with ambulation. R2 would take shuffling her feet, knees rubbing against each other, taking a bit of time to take a step and then suddenly R2's knees would buckle, and she would start to drop. The medical record lacked an assessment from physical therapy and/or an assessment from nursing related to the decline in physical abilities. During interview on 7/29/25, at 2:40 p.m. trained medical assistant (TMA)-B stated R2 was ambulating a few months ago but did not now. R2 would lean heavily to one side, and it just was not safe for her to ambulate. R2 was still able to stand and pivot most of the time. TMA-B was not sure if therapy worked with R2 after she stopped ambulating. TMA-B did not think anything specific had occurred, and thought it was related to a decline in her general condition. During observation on 7/29/25, at 6:29 p.m., nursing assistant (NA)-A assisted R2 to wash and dry and put on a nightgown. NA-A put a gait belt around R2's waist and instructed her to grab on to the grab bar and stand. NA-A assisted R2 to a standing position and finished peri care and put on a disposable brief. NA-A assisted R2 to pivot and sit in her wheelchair. R2 was able to bear weight but was unable to take a full step to pivot and became unsteady, with knees knocking together. NA-A assisted R2 to sit down in the wheelchair quickly due to R2 was becoming off balance. NA-A stated R2 used to walk but was no longer able to. R2 usually could transfer with one person but occasionally would need two and the stand lift. When interviewed on 7/30/25, at 8:29 a.m. registered		F0676				

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F0676 SS = D	Continued from page 8 nurse (RN)-A stated she completed the MDS's for the residents in the facility. She considered a significant change with residents when they returned from the hospital and there were changes with the resident's abilities, as well as when the facility nurses or nursing assistants reported changes or a decline noted with residents. When a resident needed more assistance with ADLs, had memory changes or wound with delayed healing a significant change MDS would be needed. There had been an order for therapy to see R2 and she had not realized that was not completed yet. They should have seen her to evaluate the decline in physical mobility. She should have followed up with therapy and that had gotten missed. Therapy usually was good about communicating with nursing staff and nursing should have followed up with them to ensure the assessment had been completed as that would have helped them to trigger R2 was a significant change as well. RN-A stated she knew R2 was having some cognitive issues as well. Further, RN-A stated she should have done a significant change instead of her last quarterly or documented why she felt one was not required, if she felt was more of an acute change and was not anticipated to be a permanent decline. During interview on 7/30/25, at 9:30 a.m. physical therapist (PT)-A stated he had received an order to do a physical therapy evaluation with R2 on 6/5/25. He had attempted to see R2 on a few occasions, but she had not been available each time he tried. R2 had either been in the bathroom or attending activities and so an evaluation had not been completed. It was a long time since therapy had received that order and R2 should have been seen. It would be important to have R2 evaluated more timely to correspond with her last MDS observation period to determine if a significant decline in her physical condition had occurred. Usually therapy communicated with the facility staff to notify them the evaluation had not been completed but with R2's case they had not done so. R2's physician had not been notified of the delay with R2's physical therapy evaluation either. During interview on 7/30/25, at 1:35 p.m. the director of nursing (DON) stated therapy should have evaluated R2's ambulation and transfers when they had received the order on 6/5/25. The facility's undated Therapy Order Checklist identified if a therapy evaluation was not completed within three business days for non-medicare stays the therapy would be contacted requesting an anticipated completion date and the provider and resident would be updated with the reason for the delay. Therapy would			F0676			

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F0676 SS = D	Continued from page 9 document all attempts that had been made to complete the resident's evaluation and nursing would continue to follow up with therapies until the evaluation was completed. For skilled therapy orders the evaluation would be completed within twenty-four hours of admission. A physical therapy policy was requested; however, none was received.	F0676		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure range of motion (ROM) was completed in accordance as care planned from therapy recommendations to prevent the loss of mobility for 1 of 3 residents (R17) reviewed for restorative nursing services. Findings include: R17's Therapy Screening Form dated 9/28/23, identified the physical therapist had reviewed R17's Functional Maintenance Program and ROM. R17 stated stretching felt good and staff were to continue with her current restorative program three times per week. R17's care plan dated 5/24/25, identified R17 had impaired mobility related to multiple sclerosis with a long-term goal to transfer into her wheelchair at least one time daily. Approaches included restorative nursing to assist R17 with ROM to both upper and lower extremities three times weekly. R17's quarterly Minimum	F0688	R17's care plan was reviewed for accuracy. R17 reported she wanted to continue with the wellness care plan as it was. R17 and staff were educated on when R17 refusals would be documented to show adherence to wellness care plan. All applicable staff were educated on the documentation of resident refusals of ADLs, mobility, and ROM attempts and on the need to document both completed and refused wellness and restorative tasks. All charts of residents on wellness and restorative programs were reviewed and updated as necessary. Charts of residents on wellness and restorative programs will be reviewed monthly for completion or resident declinations of interventions. All wellness and restorative programs will be reviewed by the IDT monthly for the need of updates or revisions. Audits of wellness and restorative programs will be conducted weekly times 4 weeks, then monthly and as needed. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed.	08/01/2025

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F0688 SS = D	Continued from page 10 Data Set (MDS) dated 5/28/25, identified R17 had intact cognition, was dependent on staff with all activities of daily living (ADLs) and was unable to ambulate. Diagnoses included multiple sclerosis, chronic obstructive pulmonary disease, anxiety, and chronic pain. R17's Point of Care History for restorative nursing identified the following:June 2025, identified R17 was offered ROM exercises two times per week and not the three times per week ordered by therapy and identified in R17's care plan. July 2025, identified R17 was offered ROM exercises one time per week for three weeks. Two times per week for one week and was not offered any exercise for one week during the month.During interview on 7/30/25, at 12:23 p.m. trained medication aide (TMA)-A stated she mainly worked in restorative nursing as an exercise technician. TMA-A did go to R17's room and offer exercises as care planned, however, R17 would frequently refuse. She thought she offered the exercises more than identified on the point of care history; however, TMA-A did not chart refused or unavailable as often as she should have. The documentation did not reflect the three times per week exercises as ordered and she felt she needed to improve her documentation. When interviewed on 7/30/25, registered nurse (RN)-A, who assisted to coordinate the restorative nursing program, stated a therapist set up the resident exercises and put the instructions in the facility restorative book for the restorative aides to follow. The restorative aide should be offering R17 exercises three times per week and document when R17 refused or was unavailable. When interviewed on 7/30/25, at 1:35 p.m. the director of nursing (DON) stated restorative nursing should offer residents exercises as directed on their plan of care and unavailability or refusals should be documented each time it occurred. During interview on 7/30/25, at 3:13 p.m. R17 stated the staff did not ask her to do exercises very often and there were times when she was asked and refused them. She felt the staff asked her about exercises when she was in the middle of working on her computer games and then she refused. They never offered to come back at a later time, and she never asked them to come back either as they were always so busy. R17 stated staff never offered exercises very often anyway. It would be nice if they offered it daily, but they did not. The most staff came in and offered was one or two times per week. Some weeks they did not offer exercise at all. A policy for restorative nursing was requested, however, none were received.			F0688			
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)			F0755	R11's EMAR was reviewed and compared to the resident's weight recordings. Medication error documentation completed. This included review of R11's care plan,		08/05/2025

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F0755 SS = D	Continued from page 11 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide medications as ordered for 1 of 5 residents (R11) reviewed for medication management. Findings include: R11's admission Minimum Data Set (MDS) dated 6/15/25, identified R11 had moderate impaired cognition and had an indwelling catheter. Diagnoses included cystitis, retention of urine., atrial fibrillation, and peripheral venous insufficiency. R11's Physician Orders dated 6/9/25, included furosemide (a diuretic to treat fluid retention) 40 milligrams (mg) to give for a 3 pound (lb.) weight gain overnight. The medication was to be given once in the morning as needed (PRN) and daily	F0755	Continued from page 11 medication list, vitals, orders, progress notes, and staff providing care to determine the root cause analysis that cause the error. On 7/29/25, education was provided to the administering nurse on 6 rights of medication administration and indications for prn administration of furosemide. R11's provider was updated. All resident records were reviewed for PRN diuretics and updated as needed. Education provided to all staff responsible for administering medications on the 6 rights of medication administration and the appropriate indications for administration of PRN medications. Resident-specific parameters will be added as needed to the EHR to alert staff when weight or specific vitals are out of the desired range per physician orders. Spreadsheet created to track resident with medication orders which have parameters for administration based on the resident's vitals or weight. Audits of PRN medications will be conducted weekly times 4 weeks for compliance with physician ordered parameters, then monthly and as needed. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed.	

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F0755 SS = D	Continued from page 12 weights were to be obtained once in the mornings to give PRN furosemide, if R11 gained three pounds (lb.) in one day. R11's June 2025 Medication Administration Record (MAR) and corresponding weights were reviewed from 6/1/25 to 6/30/25 and identified the following:On 6/23/25 40 mg of Lasix was given for for a 3 lb. weight gain in a day, however, R11's weight on 6/22/25 was 181.9 lbs. and was 183 lbs. on 6/23, which was a weight gain of only 1 lb. 9 oz.On 6/26/25, 40 mg of Lasix was given for for a 3 lb. weight gain in a day, however, R11's weight on 6/25/25 was 183.9 lbs. and was 184.9 lbs. on 6/26/25, which was 9 oz. gain.R11's July 2025 MAR, and corresponding weights were reviewed from 7/1/25 to 7/30/25 and identified the following:On 7/9/25, 40 mg of Lasix was given for for a five percent weight gain, however, R11's weight had not been recorded the day prior, and it could not be determined if R11 had a 3 lb. weight gain. On 7/29/25, at 6:47 p.m. R11 was observed to have swelling in both lower extremities. During interview on 7/30/25, at 9:14 a.m. registered nurse (RN)-B stated R11 had an order to administer furosemide if R11 had a weight gain of 3 lbs. or more in one day. The nurse was to document the weight on the resident's MAR as well as the administration of the PRN furosemide and its effectiveness. Some of the nurses would also document the weight and administration of the PRN medication in the resident progress notes. RN-B believed the furosemide administered on 6/23/25, 6/26/25 and 7/9/25, were given in error and she would fill out medication error reports for all three of the days. During interview on 7/30/25, at 1:35 p.m. the director of nursing (DON) stated the nurse should have clarified the PRN furosemide order before administering the medication. They had identified it was the same nurse making the medication errors and had educated her on the intent of the order and the process for obtaining and evaluating R11's weights as well when the PRN furosemide was to be administered. On 7/30/25, at 2:45 p.m. a call was attempted to R11's primary physician, however, was not returned. During telephone interview on 7/30/25, at 3:30 p.m. the facility's consultant pharmacist (CP)-C stated although R11 did receive furosemide in error on three occasions it probably was not a significant medication error, especially because R11 did not have an order to receive scheduled regularly scheduled furosemide. It would be more significant if he did receive furosemide scheduled daily and then received additional doses in error because then it could affect some of his lab values such as sodium and potassium or would worry about dehydration. Because he only received it occasionally for weight gain over 3 lbs. the three additional doses spread out throughout the two months would not be		F0755				

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F0755 SS = D	Continued from page 13 clinically significant. The facility policy Medication Management dated 8/8/24, directed nursing staff prior to administration, a medication and dosage schedule on the MAR was to be compared with the medication label. For orders with physician parameters for administration, the nurse was to verify the medication met the ordered parameters (i.e. specific range or values of weight, blood pressure, pulse blood glucose, oxygen saturations, etc.).	F0755		
F0880 SS = D	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: (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;	F0880	Nursing assistant (NA)-B received immediate education on 7/29/25 by Nursing on the Enhanced Barrier Precautions (EBP) policy, residents requiring EBP, and interactions requiring EBP. All resident records reviewed for the need for EBP and care plans were updated as necessary. All staff were educated on the EBP policy, residents requiring EBP, and which cares/interactions require the use of EBP. Monthly audits of appropriate use of EBP and knowledge of EBP policy, including the residents and the residents' cares/interactions requiring EBP will be completed. Just in time education will be, provided if staff do not use EBP when indicated per policy. Audits of EPB compliance will be conducted weekly times 4 weeks, then monthly and as needed. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed.	07/30/2025

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F0880 SS = D	Continued from page 14 (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: Based on observation, interview and document review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented in accordance with Centers for Disease Control (CDC) recommendations during personal care for 1 of 1 residents (R11) reviewed who had a catheter. Findings include: A CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) manual, dated 7/2022, identified MDRO transmission within a nursing home was common and contributed to substantial resident morbidity and mortality. The feature outlined EBP were		F0880				

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F0880 SS = D	Continued from page 15 defined as, " ... expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing ... MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities ... residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs." The feature identified several examples of high-contact resident care activities including dressing, bathing, providing hygiene, transferring, changing linens or briefs, and wound care. R11's admission Minimum Data Set (MDS) dated 6/15/25, identified R11 had moderate impaired cognition and required moderate to maximum assistance with dressing, and grooming and supervision with bed mobility, transfers. R2 had an indwelling catheter. Diagnoses included cystitis and retention of urine. R11's care plan dated 7/22/25, identified R11 had an indwelling catheter due to urinary retention and required enhanced barrier precautions (EBP) during high contact cares. On 7/29/25, at 1:27 p.m. R11's room was observed from the hallway which had an orange-colored sign posted on the door which read Enhanced Barrier Precautions...Providers and staff must also: Wear gloves and gown for the following high contact resident care activities...dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assistance with toileting...the signage was provided from the CDC. Inside the room, a hard plastic cart with drawers with gowns and other PPE supplies was located inside R11's bathroom. During observation on 7/29/25, at 6:47 p.m. nursing assistant (NA)-B was assisting R11 to prepare for bed. R11 was lying on his bed and NA-B was at R11's bedside. NA-B was not wearing a disposable gown. NA-B obtained a wash basin with warm water and washcloth from R11's bathroom and donned disposable gloves, NA-B did not put on a disposable gown. NA-B opened R11's brief and preceded to wash R11's groin and peri area. NA-B leaned over the bedside while washing and NA-B's uniform touched R11's bed and upper thigh, while washing the groin area. NA-B finished washing and drying R11's peri area, removed his gloves and called for the nurse on his walkie. Registered nurse (RN)-D entered R11's room and put on gloves. RN-D did not put on a disposable gown. RN-D manipulated R11's catheter near the tip of the penis, pulled R11's foreskin back and instructed NA-B to continue to try to wash the cream off of R11's			F0880			

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NAME OF PROVIDER OR SUPPLIER First Care Living Center				STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST , FOSSTON, Minnesota, 56542			
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F0880 SS = D	Continued from page 16 groin, stating R11 had a lot of cream build up in the area. RN-D removed her gloves, applied alcohol-based hand sanitizer (ABHR) to her hands and exited the room. NA-B donned disposable gloves and without gowning, continued to wash and then dry R11's groin and peri are. NA-B, after removing their gloves called for the nurse on the walkie. RN-D entered R11's room, donned disposable gloves, but did not don a disposable gown, and applied the prescription cream to R11's groin and penis. RN-D removed her gloves, applied ABHR to her hands and exited the room. After cleaning up the bedside, NA-B washed his hands, put on a disposable gown and donned gloves. NA-B stated he was donning the disposable gown because he planned to drain R11's catheter. NA-B emptied R11's catheter, rinsed and put away the urinal and removed his PPE. During interview on 7/29/25, at 7:38 p.m. NA-B stated he had not been instructed to wear PPE when assisting R11 with personal care, only when working with R11's catheter. NA-B reviewed the EBP signage located on R11's door, NA-B verified the sign instructed staff to wear gown and gloves when assisting the resident with bath, transfers, cares, dressing, grooming and personal care. NA-B stated he should have been wearing a gown and gloves when he assisted R11 to prepare for bed and that was his mistake, he had screwed up. When interviewed on 7/29/25, at 7:39 p.m. RN-D verified she had manipulated R11's catheter near his penis and put on prescribed cream without donning a disposable gown. RN-D stated R11 was on EBP and she should have had a gown on when she assisted with R11's care. It was important to wear a gown and gloves when providing personal care when a resident was under EBP to prevent staff from bringing the germs out into the facility and to protect the other residents. She had not realized NA-B was not wearing a gown when providing care to R11 either and he should have been wearing one as well. During interview on 7/30/25, at 9:21 a.m. RN-E stated she was in charge of the infection control program for the facility. Staff had been educated to wear gown and gloves when they assisted a resident with personal cares if the resident was under EBP. The facility staff had been educated the PPE needed to be worn with all care and not just catheter care when EBP's were in place. RN-E did not know why the appropriate PPE had not been worn when NA-B and RN-D had been assisting R11 with bedtime cares, as they should have known better. When interviewed on 7/30/25, at 1:35 p.m. the director of nursing (DON) stated all staff had been educated on the appropriate use of PPE when a resident was under		F0880				

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

FORM APPROVED
OMB NO. 0938-0391

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F0880 SS = D	Continued from page 17 EBP's and they should have known when and how to use PPE when they had provided assistance to R11 with personal care. The facility policy Enhanced Barrier Precaution's dated 7/1/24, identified EBP was used in long term care settings and referred to the use of gown and gloves during high-contact care activities that provided opportunities for transfer of multidrug resistant organisms (MDROs) to staff hands and clothing. Staff were to initiate PPE use of gowns and gloves during the following high contact resident care activities: dressing, bathing, transferring, providing hygiene, changing linens, and changing briefs or toileting as well as device care or use with central lines, urinary catheters, feeding tubes, or tracheostomy/ventilator care.			F0880			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245512		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME B. WING		(X3) DATE SURVEY COMPLETED 07/29/2025	
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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/29/2025. At the time of this survey, First are Living Center / Essentia Health Fosston was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR			K0000			08/18/2025

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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K0000	Continued from page 1 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. Essentia Health NH is a 1-story building without a basement. The building was constructed at 2 different times. The original building was constructed in 1972 and was determined to be of Type II(111) construction. In 1997, additions to the sleeping rooms and an activates room to the north east corner were constructed. Theses additions are Type II(111) construction. The building is divided into 4 smoke zones with a 30 minute and two 2-hour fire barriers. The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Automatic Sprinkler Systems . The facility has a fire alarm system with smoke detection in the corridor system, in all sleeping rooms and in common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" . The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system. The facility has a capacity of 50 beds and had a census		K0000				

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K0000	Continued from page 2 of 43 at the time of the survey.			K0000			
K0321 SS = D	The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by:			K0321	Automatic door closure installed. All storage room doors will be audited to verify self closures are installed and functioning properly. Audits of storage room doors will be completed monthly and as needed. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed. Maintenance supervisor responsible for completion of install. Nursing director responsible to oversee audits are completed by maintenance and/or long term care staff.		08/25/2025

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K0321 SS = D	Continued from page 3 Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have an isolated impact on the residents within the facility. Findings include: On On 07/29/2025 at 12:12pm, it was revealed by observation that the therapy storage room did not have a self-closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0321			
K0324 SS = D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited 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 STANDARD is NOT MET as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding			K0324	Hood inspection had been completed on April 29, 2025. Report added to maintenance binder. Maintenance supervisor will verify reports are in binder upon completion. Audits will be completed monthly and as needed. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed. Maintenance supervisor will be responsible to ensure inspection are competed and report stored in binder. Nursing Director is responsible for oversight of audits.		07/29/2025

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K0324 SS = D	Continued from page 4 could have an isolated impact on the residents within the facility. Findings Include: On On 07/29/2025 at 11:28am, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for one (1) of the semi-annual kitchen hood suppression system inspections for the last 12 months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0324			
K0345 SS = E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 14.2.1.2.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On On 07/29/2025 at 11:20am, it was revealed by a review of available documentation that the annual fire alarm inspection report produced by Johnson Control dated 09/06/2024 that the facility did provide documentation that a sensitivity testing had been conducted, but during review the documents only contained a pass/fail indication. The documents must contain a percentage rating to be considered complete. An interview with the Maintenance Director verified			K0345	Maintenance supervisor contacted vendor to obtain a percentage rating on sensitivity testing. Maintenance supervisor working with vendor to obtain a percentage on sensitivity testing rather than a pass/fail result. Audits will be completed to verify sensitivity testing includes a percentage rating. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed. Maintenance supervisor will be responsible to ensure inspection are competed and report stored in binder. Nursing Director is responsible for oversight of audits.		09/15/2025

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K0345 SS = E	Continued from page 5 this deficient finding at the time of discovery.		K0345				
K0355 SS = D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On On 07/29/2025 at 11:29am, it was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0355	Fir extinguisher annual inspection had been completed on May 21 , 2025. Maintenance supervisor contacted vendor for copy of the report. Report was added to maintenance binder. Maintenance supervisor will verify reports are in binder upon completion. Audits will be completed monthly and as needed. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed. Maintenance supervisor will be responsible to ensure inspection are competed and report stored in binder. Nursing Director is responsible for oversight of audits.		07/29/2025	
K0363 SS = D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is		K0363	Vent in room 319 was adjusted to increase the negative pressure to aide in door closures. Door closures will be checked during facility walk throughs to verify doors are closing properly. Doors found to not close properly will be checked and adjustments made. Audits will be completed monthly and as needed. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed. Maintenance supervisor will be responsible to ensure inspection are competed and report stored in binder. Nursing Director is responsible for oversight of		07/29/2025	

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K0363 SS = D	Continued from page 6 not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 07/29/2025 at 12:35pm, it was revealed by observation that the environmental services room (319) does not latch. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0363	Continued from page 6 audits.		
K0372 SS = E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.			K0372	Fire caulking added to areas identified. Maintenance developing a ceiling access process for contractors to require all ceiling work be signed off by maintenance supervisor upon completion. Audits will be completed monthly and as needed. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed.		07/29/2025

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K0372 SS = E	Continued from page 7 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/29/25 at the following times, it was revealed by observation that there was a penetration running from one smoke compartment to another above the following areas: 1) At 11:52am, Boiler room wall 2) At 12:03pm, Above North Wing doors 3) At 12:05pm, Above West Wing doors An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0372	Continued from page 7 Maintenance supervisor will be responsible to ensure inspection are competed and report stored in binder. Nursing Director is responsible for oversight of audits.		
K0712 SS = F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD 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			K0712	New fire drill sheets were created with different sheets for each shift to ensure proper timing of fire drills. Maintenance supervisor will maintain records and verify the time of the fire drill meets regulatory requirements. Audits will be completed quartely and as needed to verify time are correct on drills. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed. Maintenance supervisor will be responsible to ensure inspection are competed and report stored in binder. Nursing Director is responsible for oversight of audits.		08/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245512		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME B. WING		(X3) DATE SURVEY COMPLETED 07/29/2025	
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K0712 SS = F	Continued from page 8 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/29/2025 at 11:17am, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement. A pattern time frame that shows that the fire drills can be anticipated by staff. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0712				
K0914 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 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 STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include:		K0914	Maintenance staff inspecting all receptacles in facility. Maintenance supervisor working with contractor to replace all receptacles to hospital grade receptacles. Audits will be completed biannually and as needed. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed. Maintenance supervisor will be responsible to ensure inspection are competed and report stored in binder. Nursing Director is responsible for oversight of audits.		08/29/2025	

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K0914 SS = F	Continued from page 9 On 07/29/2025 at 11:45am, it was revealed by review of available documentation the required annual receptacle inspection documentation was not available at the time of the survey. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0914		
K0918 SS = F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for	K0918	Emergency generator maintenance and testing annual generator inspection was completed on 12/10/24. Next due service date is 12/2027. Report added to maintenance binder. Maintenance supervisor will verify reports are in binder upon completion. Audits will be completed as needed. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed. Maintenance supervisor will be responsible to ensure inspection are competed and report stored in binder. Nursing Director is responsible for oversight of audits.	08/15/2025

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K0918 SS = F	Continued from page 10 Emergency and Standby Power Systems, sections 5.6.5.2, 5.6.5, 5.6.5.6, 5.6.5.6.1, 5.6.6, 8.3.8,8.4.1, 8.4.2.1, 8.4.2.3,8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 07/29/2025 at 11:17am, it was revealed by a review of available documentation of the emergency generator maintenance and testing that an annual generator inspection was not performed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.		K0918				
K0920 SS = D Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility.		K0920	Refrigerator was moved to a dedicated outlet. Staff educated on use of power strips and items requiring dedicated outlets. Audits will be completed as needed. Results of these audits will be reviewed by the QAPI committee who will determine a plan for ongoing auditing based on these results. The Director of Nursing will be responsible for ensuring this plan of correction is followed. Maintenance supervisor will be responsible to ensure inspection are competed and report stored in binder. Nursing Director is responsible for oversight of audits.		07/29/2025	

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K0920 SS = D Bldg. 01	Continued from page 11 Findings include: On On 07/29/2025 at 12:48pm, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following area; extension cord plugging in Home Health Care Office. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0920			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 15, 2025

Administrator

First Care Living Center

900 HILLIGOSS BOULEVARD SOUTHEAST

FOSSTON, MN 56542

Re: State Nursing Home Licensing Orders

Event ID: WA3T11

Dear Administrator:

The above facility was surveyed on July 30, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software.

Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15

days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER First Care Living Center				STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST , FOSSTON, Minnesota, 56542			
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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/28/25 through 7/30/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.		20000			08/20/2025	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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Minnesota State Department of Health

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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.		20000				
20550	Comprehensive Resident Assessment; Review CFR(s): MN Rule 4658.0400 Subp. 4 Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to revise the care plan to remove restorative nursing ambulation program from the care plan for 1 of 4 resident (R15) reviewed for restorative nurse		20550	Corrected		08/01/2025	

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20550	Continued from page 2 services. Findings include: R2's quarterly MDS dated 4/2/25, identified R2 had severe cognitive impairment. R2 was independent with eating and could turn and reposition herself in bed. R2 required moderate assistance to sit up, toilet, transfers and ambulate 10 feet, 50 feet and 150 feet. Diagnoses included malignant neoplasm of breasts, dementia and low back pain. R2's quarterly MDS dated 7/2/25, identified R2 had severe cognitive impairment. R2 required set up with eating and moderate assistance to turn and reposition when in bed. R2 required maximum assistance to sit up, toilet, transfers and ambulation 10 feet. Ambulation 50 and 150 feet were not attempted due to medical condition or safety concerns. R2's care plan with review date 6/27/25, identified R2 required assistance with activities of daily living (ADLs) and was at risk for needing more assistance due to changing cognitive ability. Staff were instructed to use extensive assist of two or three persons to ambulate, and R2 was independent with bed mobility. R2 needed moderate to maximum assistance with dressing and extensive assist of one to two persons with transfers and toileting. R2's care plan had not been updated to reflect her more current functional assessments and decline in physical mobility. R2's Functional Abilities Assessment dated 7/3/25, identified R2 required setup with eating and assist of one with toileting, grooming, bed mobility, toileting, transfers, and dressing. R2 was having more difficulty with ambulation, dependent with ambulation up to 10 feet and was unable to ambulate any further. R2's progress notes were reviewed 6/1/25 through 7/27/25 and identified the following;6/4/25, identified staff had concerns with R2's ambulation, needing two persons to ambulate and another with the wheelchair behind as R2 tilted badly to the side with ambulating. R2 was requiring a stand lift to transfer more in the evenings.6/4/25, an order was obtained for a physical therapy evaluation and treatment for ambulation and transfers.6/5/25, staff identified R2 needed a lot of encouragement with ambulation. R2 would take shuffling her feet, knees rubbing against each other, taking a bit of time to take a step and then suddenly R2's knees would buckle, and she would start to drop.6/26/25, a significant weight loss was identified, as R2 had lost 8 pounds, 5 percent, in 28 days.During interview on		20550				

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20550	Continued from page 3 7/29/25, at 2:40 p.m. trained medical assistant (TMA)-B stated R2 used to ambulate but did not now. R2 would lean heavily to one side, and it just was not safe for her to ambulate. R2 was still able to stand and pivot most of the time. TMA-B was not sure if therapy worked with R2 after she stopped ambulating. TMA-B did not think anything specific had occurred, and thought it was related to a decline in her general condition. During observation on 7/29/25, at 6:29 p.m., nursing assistant (NA)-A was assisting R2 to wash and dry and put on a nightgown, NA-A put a gait belt around R2's waist and instructed her to grab on to the grab bar and stand. NA-A assisted R2 to a standing position and finished peri care and put on a disposable brief. NA-A assisted R2 to pivot and sit in her wheelchair. R2 was able to bear weight but unable to take a full step to pivot and became unsteady, with knees knocking together. NA-A assisted R2 to sit down in the wheelchair quickly due to R2 becoming off balance. NA-A stated R2 used to walk but was no longer able to. R2 usually could transfer with one person but occasionally would need two and the stand lift. When interviewed on 7/30/25, at 8:29 a.m. registered nurse (RN)-A stated she completed the MDS's for the residents in the facility. She considered a significant change with residents when they returned from the hospital and there were changes with the resident's abilities, as well as when the facility nurses or nursing assistants reported changes or a decline noted with residents. When a resident needed more assistance with ADLs, had memory changes or wound with delayed healing a significant change MDS would be needed. There had been an order for therapy to see R2 and she had not realized that was not completed yet. They should have seen her to evaluate the decline in physical mobility. She should have followed up with therapy and that had gotten missed. Therapy usually was good about communicating with nursing staff and nursing should have followed up with them to ensure the assessment had been completed as that would have helped them to trigger R2 was a significant change as well. RN-A stated she knew R2 was having some cognitive issues as well. Further, RN-A stated she should have done a significant change instead of her last quarterly or documented why she felt one was not required, if she felt was more of an acute change and was not anticipated to be a permanent decline. During interview on 7/30/25, at 1:35 p.m. the director of nursing (DON) stated R2 should have had a significant change MDS completed instead of a quarterly due to the decline in her physical abilities.		20550				

Minnesota State Department of Health

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20550	Continued from page 4 The Centers for Medicaid and Medicare Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual pages 2-21 through 2-28 identified a significant change in assessment (SCSA) was appropriate if there were two or more changes in the following areas: decision making ability, presence of a mood item not previously recorded, changes in frequency or severity of behaviors, any decline in an ADL physical functioning area where a resident was newly coded as moderate, maximum assistance, dependent or activity not attempted since last assessment, incontinence pattern changes, placement of indwelling catheter, or the emergence of unplanned weight loss of 5% in 30 days or 10% in 180 days, emergence of a new pressure ulcer stage two or higher, or use of a new restraint. The facility policy Notification of Condition dated 7/5/24, identified the nurse would update the resident's care plan, communicate the changes to the rest of the care team and the interdisciplinary team would review the resident with changes in condition to determine if a significant change MDS was needed based on the resident assessment instrument guidelines. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related to significant change in Minimum Data Set (MDS)assessments, including identification of when a significant change in condition has occurred and collection of required information. The DON or designee could educate staff to policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20550				
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the		20570	Corrected		08/01/2025	

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20570	Continued from page 5 comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to revise the care plan to remove restorative nursing ambulation program from the care plan for 1 of 4 resident (R15) reviewed for restorative nurse services. Findings include: R15's quarterly Minimum Data Set (MDS) dated 6/4/25, identified R15 had severe cognitive impairment and identified R15 was dependent of staff for transfers and bed mobility and R15 did not ambulate (walk). R15's care plan dated 6/3/25 identified:R15 was to ambulate with an assist of two of the restorative aides assisting, until physical therapy (PT) provided further treatment.R15 was on a wellness ambulation program that indicated R15 would ambulate daily or as tolerated with restorative.R15's doctor's note from 11/14/24, identified R15 had declined and was no longer able to walk. R15 behavioral health note from 12/31/24, identified resident was no longer ambulating. During an interview on 7/29/25 at 2:12 p.m., family member (FM)-A stated R15 had not walked for close to a year. During interview on 7/30/25 at 8:21 a.m., trained medication assistant (TMA)-C stated they had been working here for a couple of years and had not seen R15 walk. During interview on 7/30/25 at 9:00 a.m., TMA-A (who also work as a restorative aide) stated R15 was able to stand and transferred from bed to wheelchair. R15 had not been able to walk and was not receiving ambulation services. During interview on 7/30/25 at 12:30 p.m., registered nurse (RN)-B stated at one time R15 was able to walk but it was a long time ago. The care plan should have been updated when there was a change in R15's walking abilities. During interview on 7/30/25 at 12:37 p.m., RN-C stated R15 had not been ambulatory since they were in their current position, which was about a year. Care plans		20570				

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20570	Continued from page 6 were to be reviewed every three months, or if there was a change in a resident's status. R15 was not ambulating, and the care plan should have reflected that. During interview on 7/30/25 at 12:41 p.m., the director of nursing (DON) stated it was an expectation a resident's care plan was to be reviewed every three months or sooner if there had been a change in a resident's status. R15 was not ambulatory, and the care plan should have been updated. The facility's Care Planning-Care Conferences policy dated 8/9/24, identified to reviewed and updated plan of care quarterly and with any change in resident condition or care needs. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20570				
20895	Rehab - Range of Motion CFR(s): MN Rule 4658.0525 Subp. 2.B Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure range of motion (ROM) was completed in accordance as care planned from therapy recommendations to prevent the loss of mobility for 1 of 3 residents (R17) reviewed for restorative nursing services. Findings include:		20895	Corrected		08/15/2025	

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20895	Continued from page 7 R17's Therapy Screening Form dated 9/28/23, identified the physical therapist had reviewed R17's Functional Maintenance Program and ROM. R17 stated stretching felt good and staff were to continue with her current restorative program three times per week. R17's care plan dated 5/24/25, identified R17 had impaired mobility related to multiple sclerosis with a long-term goal to transfer into her wheelchair at least one time daily. Approaches included restorative nursing to assist R17 with ROM to both upper and lower extremities three times weekly. R17's quarterly Minimum Data Set (MDS) dated 5/28/25, identified R17 had intact cognition, was dependent on staff with all activities of daily living (ADLs) and was unable to ambulate. Diagnoses included multiple sclerosis, chronic obstructive pulmonary disease, anxiety, and chronic pain. R17's Point of Care History for restorative nursing identified the following:June 2025, identified R17 was offered ROM exercises two times per week and not the three times per week ordered by therapy and identified in R17's care plan. July 2025, identified R17 was offered ROM exercises one time per week for three weeks. Two times per week for one week and was not offered any exercise for one week during the month.During interview on 7/30/25, at 12:23 p.m. trained medication aide (TMA)-A stated she mainly worked in restorative nursing as an exercise technician. TMA-A did go to R17's room and offer exercises as care planned, however, R17 would frequently refuse. She thought she offered the exercises more than identified on the point of care history; however, TMA-A did not chart refused or unavailable as often as she should have. The documentation did not reflect the three times per week exercises as ordered and she felt she needed to improve her documentation. When interviewed on 7/30/25, registered nurse (RN)-A, who assisted to coordinate the restorative nursing program, stated a therapist set up the resident exercises and put the instructions in the facility restorative book for the restorative aides to follow. The restorative aide should be offering R17 exercises three times per week and document when R17 refused or was unavailable. When interviewed on 7/30/25, at 1:35 p.m. the director of nursing (DON) stated restorative nursing should offer residents exercises as directed on their plan of		20895				

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20895	Continued from page 8 care and unavailability or refusals should be documented each time it occurred. During interview on 7/30/25, at 3:13 p.m. R17 stated the staff did not ask her to do exercises very often and there were times when she was asked and refused them. She felt the staff asked her about exercises when she was in the middle of working on her computer games and then she refused. They never offered to come back at a later time, and she never asked them to come back either as they were always so busy. R17 stated staff never offered exercises very often anyway. It would be nice if they offered it daily, but they did not. The most staff came in and offered was one or two times per week. Some weeks they did not offer exercise at all. A policy for restorative nursing was requested, however, none were received. SUGGESTED METHOD OF CORRECTION: The DON or designee, could review all residents at risk for limited range of motion/ambulation to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The DON or designee, could educate staff and conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20895				
20915	Rehab - ADLs CFR(s): MN Rule 4658.0525 Subp. 6 A Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet;		20915	Corrected		08/01/2025	

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20915	Continued from page 9 (4) eat; and (5) use speech, language, or other functional communication systems; and This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess for a decline in activities in daily living (ADL) and ensure a referral from physical therapy for the decline in ADL's was acted upon for for 1 of 5 residents (R2) reviewed for ADL's Findings include: R2's quarterly Minimum Data Set (MDS) dated 4/2/25, identified R2 had severe cognitive impairment. R2 was independent with eating and could turn and reposition herself in bed. R2 required moderate assistance to sit up, toilet, transfers and ambulate 10 feet, 50 feet and 150 feet. Diagnoses included malignant neoplasm of breasts, dementia, atrial fibrillation (irregular heartbeat) and low back pain. R2's quarterly MDS dated 7/2/25, identified severe cognitive impairment. R2 required set up with eating and moderate assistance to turn and reposition when in bed. R2 required maximum assistance to sit up, toilet, transfers and ambulation 10 feet. Ambulation 50 and 150 feet were not attempted due to medical condition or safety concerns. R2's care plan with review date 6/27/25, identified R2 required assistance with activities of daily living (ADLs) and was at risk for needing more assistance due to changing cognitive ability. Staff were instructed to use extensive assist of two or three persons to ambulate, and R2 was independent with bed mobility. R2 needed moderate to maximum assistance with dressing and extensive assist of one to two persons with transfers and toileting. R2's care plan had not been updated to reflect her more current functional assessments and decline in physical mobility. R2's progress notes were reviewed 6/1/25 through 7/27/25 and identified the following;6/4/25, identified staff had concerns with R2's ambulation, needing two persons to ambulate and another with the wheelchair behind as R2 tilted badly to the side with ambulating. R2 was requiring a stand lift to transfer more in the evenings. 6/4/25, an order was obtained for a physical therapy evaluation and treatment for ambulation and transfers. 6/5/25, staff identified R2 needed a lot of		20915				

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20915	Continued from page 10 encouragement with ambulation. R2 would take shuffling her feet, knees rubbing against each other, taking a bit of time to take a step and then suddenly R2's knees would buckle, and she would start to drop. The medical record lacked an assessment from physical therapy and/or an assessment from nursing related to the decline in physical abilities. During interview on 7/29/25, at 2:40 p.m. trained medical assistant (TMA)-B stated R2 was ambulating a few months ago but did not now. R2 would lean heavily to one side, and it just was not safe for her to ambulate. R2 was still able to stand and pivot most of the time. TMA-B was not sure if therapy worked with R2 after she stopped ambulating. TMA-B did not think anything specific had occurred, and thought it was related to a decline in her general condition. During observation on 7/29/25, at 6:29 p.m., nursing assistant (NA)-A assisted R2 to wash and dry and put on a nightgown. NA-A put a gait belt around R2's waist and instructed her to grab on to the grab bar and stand. NA-A assisted R2 to a standing position and finished peri care and put on a disposable brief. NA-A assisted R2 to pivot and sit in her wheelchair. R2 was able to bear weight but was unable to take a full step to pivot and became unsteady, with knees knocking together. NA-A assisted R2 to sit down in the wheelchair quickly due to R2 was becoming off balance. NA-A stated R2 used to walk but was no longer able to. R2 usually could transfer with one person but occasionally would need two and the stand lift. When interviewed on 7/30/25, at 8:29 a.m. registered nurse (RN)-A stated she completed the MDS's for the residents in the facility. She considered a significant change with residents when they returned from the hospital and there were changes with the resident's abilities, as well as when the facility nurses or nursing assistants reported changes or a decline noted with residents. When a resident needed more assistance with ADLs, had memory changes or wound with delayed healing a significant change MDS would be needed. There had been an order for therapy to see R2 and she had not realized that was not completed yet. They should have seen her to evaluate the decline in physical mobility. She should have followed up with therapy and that had gotten missed. Therapy usually was good about communicating with nursing staff and nursing should have followed up with them to ensure the assessment had been completed as that would have helped them to trigger R2 was a significant change as well. RN-A stated she knew R2 was having some cognitive issues as well. Further, RN-A stated she should have done a		20915				

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20915	Continued from page 11 significant change instead of her last quarterly or documented why she felt one was not required, if she felt was more of an acute change and was not anticipated to be a permanent decline. During interview on 7/30/25, at 9:30 a.m. physical therapist (PT)-A stated he had received an order to do a physical therapy evaluation with R2 on 6/5/25. He had attempted to see R2 on a few occasions, but she had not been available each time he tried. R2 had either been in the bathroom or attending activities and so an evaluation had not been completed. It was a long time since therapy had received that order and R2 should have been seen. It would be important to have R2 evaluated more timely to correspond with her last MDS observation period to determine if a significant decline in her physical condition had occurred. Usually therapy communicated with the facility staff to notify them the evaluation had not been completed but with R2's case they had not done so. R2's physician had not been notified of the delay with R2's physical therapy evaluation either. During interview on 7/30/25, at 1:35 p.m. the director of nursing (DON) stated therapy should have evaluated R2's ambulation and transfers when they had received the order on 6/5/25. The facility's undated Therapy Order Checklist identified if a therapy evaluation was not completed within three business days for non-medicare stays the therapy would be contacted requesting an anticipated completion date and the provider and resident would be updated with the reason for the delay. Therapy would document all attempts that had been made to complete the resident's evaluation and nursing would continue to follow up with therapies until the evaluation was completed. For skilled therapy orders the evaluation would be completed within twenty-four hours of admission. A physical therapy policy was requested; however, none was received. SUGGESTED METHOD OF CORRECTION: The DON and/or designee could review and revise policies and educate responsible staff on assessment and follow through of referrals when ADL's decline. The DON or designee could conduct audits to ensure residents with ADL decline are assessed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20915				

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20915 21385	Infection Control; Staff assistance CFR(s): MN Rule 4658.0800 Subp. 3 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented in accordance with Centers for Disease Control (CDC) recommendations during personal care for 1 of 1 resident (R11) reviewed who had a catheter. Findings include: A CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) manual, dated 7/2022, identified MDRO transmission within a nursing home was common and contributed to substantial resident morbidity and mortality. The feature outlined EBP were defined as, " ... expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing ... MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities ... residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs." The feature identified several examples of high-contact resident care activities including dressing, bathing, providing hygiene, transferring, changing linens or briefs, and wound care. R11's admission Minimum Data Set (MDS) dated 6/15/25, identified R11 had moderate impaired cognition and required moderate to maximum assistance with dressing, and grooming and supervision with bed mobility, transfers. R2 had an indwelling catheter. Diagnoses included cystitis and retention of urine. R11's care plan dated 7/22/25, identified R11 had an indwelling catheter due to urinary retention and required enhanced barrier precautions (EBP) during high contact cares. On 7/29/25, at 1:27 p.m. R11's room was observed from the hallway which had an orange-colored sign posted on		20915 21385	corrected		08/01/2025	

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21385	Continued from page 13 the door which read Enhanced Barrier Precautions...Providers and staff must also: Wear gloves and gown for the following high contact resident care activities...dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assistance with toileting...the signage was provided from the CDC. Inside the room, a hard plastic cart with drawers with gowns and other PPE supplies was located inside R11's bathroom. During observation on 7/29/25, at 6:47 p.m. nursing assistant (NA)-B was assisting R11 to prepare for bed. R11 was lying on his bed and NA-B was at R11's bedside. NA-B was not wearing a disposable gown. NA-B obtained a wash basin with warm water and washcloth from R11's bathroom and donned disposable gloves, NA-B did not put on a disposable gown. NA-B opened R11's brief and preceded to wash R11's groin and peri area. NA-B leaned over the bedside while washing and NA-B's uniform touched R11's bed and upper thigh, while washing the groin area. NA-B finished washing and drying R11's peri area, removed his gloves and called for the nurse on his walkie. Registered nurse (RN)-D entered R11's room and put on gloves. RN-D did not put on a disposable gown. RN-D manipulated R11's catheter near the tip of the penis, pulled R11's foreskin back and instructed NA-B to continue to try to wash the cream off of R11's groin, stating R11 had a lot of cream build up in the area. RN-D removed her gloves, applied alcohol-based hand sanitizer (ABHR) to her hands and exited the room. NA-B donned disposable gloves and without gowning, continued to wash and then dry R11's groin and peri are. NA-B, after removing their gloves called for the nurse on the walkie. RN-D entered R11's room, donned disposable gloves, but did not don a disposable gown, and applied the prescription cream to R11's groin and penis. RN-D removed her gloves, applied ABHR to her hands and exited the room. After cleaning up the bedside, NA-B washed his hands, put on a disposable gown and donned gloves. NA-B stated he was donning the disposable gown because he planned to drain R11's catheter. NA-B emptied R11's catheter, rinsed and put away the urinal and removed his PPE. During interview on 7/29/25, at 7:38 p.m. NA-B stated he had not been instructed to wear PPE when assisting R11 with personal care, only when working with R11's catheter. NA-B reviewed the EBP signage located on R11's door, NA-B verified the sign instructed staff to wear gown and gloves when assisting the resident with bath, transfers, cares, dressing, grooming and personal care. NA-B stated he should have been wearing a gown and gloves when he assisted R11 to prepare for bed and that was his mistake, he had screwed up.		21385				

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21385	Continued from page 14 When interviewed on 7/29/25, at 7:39 p.m. RN-D verified she had manipulated R11's catheter near his penis and put on prescribed cream without donning a disposable gown. RN-D stated R11 was on EBP and she should have had a gown on when she assisted with R11's care. It was important to wear a gown and gloves when providing personal care when a resident was under EBP to prevent staff from bringing the germs out into the facility and to protect the other residents. She had not realized NA-B was not wearing a gown when providing care to R11 either and he should have been wearing one as well. During interview on 7/30/25, at 9:21 a.m. RN-E stated she was in charge of the infection control program for the facility. Staff had been educated to wear gown and gloves when they assisted a resident with personal cares if the resident was under EBP. The facility staff had been educated the PPE needed to be worn with all care and not just catheter care when EBP's were in place. RN-E did not know why the appropriate PPE had not been worn when NA-B and RN-D had been assisting R11 with bedtime cares, as they should have known better. When interviewed on 7/30/25, at 1:35 p.m. the director of nursing (DON) stated all staff had been educated on the appropriate use of PPE when a resident was under EBP's and they should have known when and how to use PPE when they had provided assistance to R11 with personal care. The facility policy Enhanced Barrier Precaution's dated 7/1/24, identified EBP was used in long term care settings and referred to the use of gown and gloves during high-contact care activities that provided opportunities for transfer of multidrug resistant organisms (MDROs) to staff hands and clothing. Staff were to initiate PPE use of gowns and gloves during the following high contact resident care activities: dressing, bathing, transferring, providing hygiene, changing linens, and changing briefs or toileting as well as device care or use with central lines, urinary catheters, feeding tubes, or tracheostomy/ventilator care. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies on EBP, educate staff on the requirements and implement a monitoring system to ensure EBP are being used as required. TIME PERIOD FOR CORRECTION: Twenty one (21) days.		21385				
21550	Adminiatration of Medications; Pharmacy Serv.		21550	corrected		07/30/2025	

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2025	
NAME OF PROVIDER OR SUPPLIER First Care Living Center				STREET ADDRESS, CITY, STATE, ZIP CODE 900 HILLIGOSS BOULEVARD SOUTHEAST , FOSSTON, Minnesota, 56542			
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21550	Continued from page 15 CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide medications as ordered for 1 of 5 residents (R11) reviewed for medication management. Findings include: R11's admission Minimum Data Set (MDS) dated 6/15/25, identified R11 had moderate impaired cognition and had an indwelling catheter. Diagnoses included cystitis, retention of urine., atrial fibrillation, and peripheral venous insufficiency. R11's Physician Orders dated 6/9/25, included furosemide (a diuretic to treat fluid retention) 40 milligrams (mg) to give for a 3-pound (lb.) weight gain overnight. The medication was to be given once in the morning as needed (PRN) and daily weights were to be obtained once in the mornings to give PRN furosemide, if R11 gained three pounds (lb.) in one day. R11's June 2025 Medication Administration Record (MAR) and corresponding weights were reviewed from 6/1/25 to 6/30/25 and identified the following:On 6/23/25 40 mg of Lasix was given for for a 3 lb. weight gain in a day, however, R11's weight on 6/22/25 was 181.9 lbs. and was 183 lbs. on 6/23, which was a weight gain of only 1 lb. 9 oz.On 6/26/25, 40 mg of Lasix was given for for a 3 lb. weight gain in a day, however, R11's weight on 6/25/25 was 183.9 lbs. and was 184.9 lbs. on 6/26/25, which was 9 oz. gain.R11's July 2025 MAR, and corresponding weights were reviewed from 7/1/25 to 7/30/25 and identified the following:On 7/9/25, 40 mg of Lasix was given for for a five percent weight gain, however, R11's weight had not been recorded the day prior, and it could not be determined if R11 had a 3 lb. weight gain. On 7/29/25, at 6:47 p.m. R11 was observed to have swelling in both lower extremities. During interview on 7/30/25, at 9:14 a.m. registered		21550				

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21550	Continued from page 16 nurse (RN)-B stated R11 had an order to administer furosemide if R11 had a weight gain of 3 lbs. or more in one day. The nurse was to document the weight on the resident's MAR as well as the administration of the PRN furosemide and its effectiveness. Some of the nurses would also document the weight and administration of the PRN medication in the resident progress notes. RN-B believed the furosemide administered on 6/23/25, 6/26/25 and 7/9/25, were given in error and she would fill out medication error reports for all three of the days. During interview on 7/30/25, at 1:35 p.m. the director of nursing (DON) stated the nurse should have clarified the PRN furosemide order before administering the medication. They had identified it was the same nurse making the medication errors and had educated her on the intent of the order and the process for obtaining and evaluating R11's weights as well when the PRN furosemide was to be administered. On 7/30/25, at 2:45 p.m. a call was attempted to R11's primary physician, however, was not returned. During telephone interview on 7/30/25, at 3:30 p.m. the facility's consultant pharmacist (CP)-C stated although R11 did receive furosemide in error on three occasions it probably was not a significant medication error, especially because R11 did not have an order to receive scheduled regularly scheduled furosemide. It would be more significant if he did receive furosemide scheduled daily and then received additional doses in error because then it could affect some of his lab values such as sodium and potassium or would worry about dehydration. Because he only received it occasionally for weight gain over 3 lbs. the three additional doses spread out throughout the two months would not be clinically significant. The facility policy Medication Management dated 8/8/24, directed nursing staff prior to administration, a medication and dosage schedule on the MAR was to be compared with the medication label. For orders with physician parameters for administration, the nurse was to verify the medication met the ordered parameters (i.e. specific range or values of weight, blood pressure, pulse blood glucose, oxygen saturations, etc.).		21550				

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21550	Continued from page 17 SUGGESTED METHOD OF CORRECTION: The DON or designee could review policies and procedures on medication errors with the consulting pharmacist and make changes where needed, then educate staff on the procedure and set up an auditing system per recommendation from the Quality Assurance Performance Improvement (QAPI) committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21550			