Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

6/26/2026

Administrator
Rochester Restorative Care Center
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: 22D6D9-H3

Dear Administrator:

On May 11, 2026, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $350.00 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation had been corrected. A reinspection was held on May 26, 2026, and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $2,450.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $249.40, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Minnesota Department of Health in the amount of $2,699.40 within 15 days of the receipt of this notice.

Please send a copy of this letter and the check to:

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64975
Financial Management
St. Paul MN 55164-0975

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

cc: Shellae Dietrich, Program Assurance Supervisor
Kami Fiske-Downing, Licensing and Certification Program
HRD Deposit Team

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June 25, 2026

Administrator
Rochester Restorative Care Center
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: March 12, 2026

Dear Administrator:

On April 29, 2026, we notified you a remedy was imposed.

On June 1, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 18, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 14, 2026, be discontinued as of May 18, 2026. (42 CFR 488.417 (b))

In our letter of April 29, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 14, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Restorative Care Center	**501 EIGHTH AVENUE SOUTHEAST , ROCHESTER, Minnesota, 55904**

(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
F0000	INITIAL COMMENTS On 5/11/26, an onsite revisit was conducted to follow up on deficiencies related to an abbreviated survey exited on 4/13/26. The facility was NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. H51841114C (254988007, 254996007, 255002009, 255090002), remained NOT IN COMPLIANCE and reissued at F803. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		05/15/2026
F0803 SS = D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received	F0803	F803 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: CNA provided immediate education on ensuring the diet provided matches the tray ticket prior to serving the meal by UM on 5/11/2026. Cook was placed on suspension pending investigation on 5/11/2026 and was termed from employment. Dietary manager was provided education on ensuring dietary staff provided meals per MD orders and menu by Regional HCSG Director of Operations on 5/12/2026	05/13/2026

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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F0803 SS = D	Continued from page 1 from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 3 residents (R8) with physician-ordered dysphagia precautions received food prepared and served in the correct texture consistency according to the resident's prescribed diet, placing the resident at risk for choking and/or aspiration. Findings include: R8's face sheet printed 5/11/26, identified diagnoses of dysphagia, oropharyngeal phase, cerebrovascular disease, and gastroesophageal reflux disease (GERD). R8's annual minimum data set (MDS) dated 2/28/26, identified R8's cognition was intact, required setup or clean-up assist with eating. R8's care area assessment (CAA) dated 2/28/26, identified the nutritional CAA triggered secondary to swallowing issues, mechanically altered diet, and dysphagia. Risk factors identified included aspiration. The CAA identified a care plan would be maintained and/or initiated to improve or maintain dietary and hydration status and monitor dietary and fluid intake. R8's care plan revised 12/3/25, identified a focus of ADL self-care deficit related to osteoarthritis, neuropathy, essential tremors, and obesity. Interventions revised 5/7/26 identified staff were to provide eating assistance including direct assist with meals, general supervision if eating in the dining room, and 1:1 intake assistance for practice of safe swallowing strategies and feeding. R8's care plan revised 4/27/26, identified a focus of obesity (Class II) related to greater energy input	F0803	Continued from page 1 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents on a mechanically altered diet have the potential to be affected. An audit was completed of tray tickets to ensure they match dietary orders, and any extraneous items are removed from tray tickets by the dietary manager on 5/12/2026 Progress notes for past 30 days were reviewed to ensure there were no other "choking" incidents documented on 5/12/2026 by DON with no other incidents What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur; and: Education with nurses/CNAs/direct care staff on the mechanically altered diet policy, diet consistency/textures, verifying diet accuracy prior to serving meals, supervision during meals, and change in condition assessment 5/12/2026 with any staff receiving education by 5/13/2026 not being allowed to work until receiving education. Huddles will be held by the floor nurse at the start of each shift to pass along any changes in resident condition or orders. Speech communication will include verification of what specific supervision is needed for those with altered diets and will be verbally given to nursing staff, written on the Therapy Communication to Nursing form and updated/uploaded into residents Medical Record, Care Plan, and staff tasks to complete. All written speech communication forms will be reviewed daily Monday – Friday as part of the clinical morning meeting process to ensure Orders, Care Plan, Kardex have been updated to reflect the appropriate diet and supervision requirements of the residents. Any communication slips generated after hours will be addressed the following morning in our clinical stand-up meeting, and any changes over the	05/13/2026

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F0803 SS = D	Continued from page 2 versus output as evidenced by a BMI of 36.3 per charting and the need for regular nutritional intake and weight monitoring. Interventions revised 5/7/26 identified staff were to provide diet as ordered: Level 3 advanced texture with ground meat and thin/regular liquid consistency. R8's comprehensive nutritional assessment dated 4/25/26, identified chewing and swallowing problems. The assessment further identified the resident experienced swallowing issues with medications during hospitalization and medications were administered one at a time in pudding or oatmeal to promote safe swallowing. R8's Situation, Background, Assessment, Recommendation (SBAR)/progress note dated 5/2/26 at 11:12 p.m., identified R8 reported choking on a tater tot during the noon meal and stated, "I really thought I was going to die." R8 later reported swallowing was difficult at times and expressed she had been considering requesting her meat be chopped finely. R8 also reported feeling short of breath following the choking episode. R8's Nurse Practitioner recertification visit dated 5/4/26, identified nursing reported an episode of aspiration the previous day. The note further identified R8 had continued to tolerate oral intake well and staff were questioning whether food alterations would be necessary. New orders identified speech therapy was to evaluate and treat R8. R8's Speech Therapy Evaluation and Plan of Treatment dated 5/5/26, identified R8 was referred for skilled speech therapy services due to a recent choking incident and difficulty swallowing. The evaluation identified R8 had been receiving regular textures and thin liquids with meal assistance due to decreased self-feeding abilities. The evaluation further identified weakness with oral musculature and mild clinical signs and symptoms of dysphagia with regular textures. Recommendations included NDD3 textures due to recent choking incident and oropharyngeal dysphagia, ground meat per resident preference, medications in puree, and 1:1 assistance for all meals to practice safe swallowing strategies and feeding due to physical deficits. Recommended compensatory strategies included small bites and sips, slow rate, alternating bites and sips, sitting upright for all intake, and 1:1 assistance/supervision. R8's Speech Therapy Treatment Encounter note dated 5/5/26 at 11:50 a.m., identified weakness with	F0803	Continued from page 2 weekend will be reviewed on Monday morning. Nurse on call will be notified of any changes in orders; nurse on call will communicate with staff and implement the changes as needed. Nurse on call 24/7. A nurse will be present in the dining room for meals to ensure appropriate diets are served, and to help monitor any choking incidents, to assist in providing general supervision of residents' dining in the dining room per the recommendations from speech therapy Residents requiring direct supervision during meals and preferring to eat in their room will have a staff member present to provide direct supervision during meals per the recommendations from speech therapy Video education followed by a written test was initiated by dietary manager with dietary cooks, dietary aides and activities staff on 5/12/2026 on diet consistency/textures and serving the appropriate diet per tray ticket with any staff not receiving education by 5/13/2026 not being allowed to work until education is completed. All altered diets will be checked by cook preparing the meal and then re-checked by dietary aide/dietary manager/designee before it leaves the kitchen to ensure food is prepared and served per the diet order. Dietary audits will be completed on all trays for all meals of high-risk residents daily x 6 days to ensure diet matches the dietary orders, 5 trays of high risk residents per week x 3 weeks to ensure diet matches the dietary order, then 3 trays of high risk residents per week x 1 week to ensure diet matches the dietary order and/or until substantial compliance is maintained and finding with be reviewed in QAPI monthly Nursing audits will be completed 5/week during mealtimes x 4 weeks to ensure appropriate diets are provided per the MD order and appropriate supervision is in place during dining and/or until substantial compliance is maintained and findings are reviewed in QAPI monthly Any non-compliance by staff in this process will lead to immediate education. Trays will be returned	05/13/2026

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F0803 SS = D	Continued from page 3 oral musculature and recommendations for NDD3 textures due to a recent choking incident and oropharyngeal dysphagia, including ground meat per resident preference and medications in puree. The note further identified R8 required 1:1 assistance for all meals to practice safe swallowing strategies and feeding due to physical deficits. Safe swallowing strategies reviewed with R8 included small bites and sips, slow rate, alternating bites and sips, and sitting upright during meals. R8's Therapy Communication to Nursing form dated 5/5/26, identified R8 was to receive NDD3 textures with ground meat and medications in applesauce. The form further identified staff were to provide 1:1 assistance for practice of safe swallowing strategies and feeding and that R8 could have general supervision if eating in the dining room. R8's Nutrition/Dietary note dated 5/5/26 at 3:48 p.m., identified speech language pathology (SLP) recommendations for National Dysphagia Diet Level 3 (NDD3) textures with ground meat. The note further identified staff were to update Meal Tracker and monitor and follow up as needed. R8's Speech Therapy Treatment Encounter note dated 5/6/26 at 11:24 a.m., identified SLP interventions to optimize oropharyngeal swallow functioning, including review of safe swallowing strategies. The note identified R8 reported staff had been assisting her with meals for a "long time" and staff were to provide assistance with meals. The note further identified R8 was encouraged to remain upright and get into her wheelchair for every meal to support safe swallowing practices. R8's SBAR/Change of Condition note dated 5/6/26 at 6:54 p.m., identified R8 had a coughing episode during the dinner meal and was having difficulty with thin liquids. The note further identified R8 was eating jellybeans in her room and asking for popcorn. Recommendations identified staff requested evaluation and further advisement. R8's verbal diet order dated 5/7/26 at 8:16 a.m., identified R8's ordered diet was Regular diet with Level 3 advanced texture, thin/regular liquid consistency, and ground meat. R8's Order Summary report printed 5/11/26, identified an active dietary order dated and started 5/7/26 for a regular diet with Level 3 advanced texture, thin/regular liquid consistency, and ground meat.	F0803	Continued from page 3 to dietary to be reviewed for accuracy and corrected if/as needed. Continued non-compliance will result in disciplinary action including suspension and up to potential termination. Describe the Quality Assurance and Process Improvement Program that will be put into place. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/13/2026	05/13/2026

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F0803 SS = D	Continued from page 4 R8's Speech Therapy Treatment Encounter note dated 5/7/26 at 12:08 p.m., identified SLP interventions to optimize airway protection and bolus efficiency. The note identified nursing aides had assisted R8 with breakfast and R8 demonstrated carryover of safe swallowing strategies, stating staff were giving "slow, small bites." The note further identified R8 required maximum hand-over-hand assistance to bring a cup to her mouth independently and demonstrated light coughing following two small sips of water. Continued recommendations included 1:1 assistance with meals for feeding and implementation of safe swallowing strategies due to dysphagia, recent choking incident, cerebrovascular disease, and physical limitations. R8's Speech Therapy Treatment Encounter note dated 5/10/26 at 3:19 p.m., identified SLP interventions and compensatory strategies to optimize oropharyngeal swallow functioning. The note identified meals had been "going better" since diet changes to NDD3 with ground meat and medications administered in puree. The note further identified R8 recalled staff providing meal assistance and practicing safe swallowing strategies, and ongoing 1:1 assistance was required for feeding due to a history of choking and dysphagia. R8's Kardex printed 5/11/26, identified staff were to provide direct assistance with meals, with 1:1 intake assistance for practice of safe swallowing strategies and feeding. The Kardex further identified R8's ordered diet was Level 3 advanced texture with ground meat and thin/regular liquid consistency. R8's breakfast tray ticket dated 5/11/26, identified R8's ordered diet was Regular – Dysphagia Advanced and included ground sausage patty and a glazed cinnamon roll. The tray ticket further identified weighted/built-up silverware, and a scoop plate were to be provided. R8's Speech Therapy Treatment Encounter note dated 5/11/26 at 11:12 a.m., identified SLP interventions and compensatory strategies to optimize airway protection and swallow efficiency during breakfast. The note identified R8 was dependent on staff for bringing all food and liquids to her mouth and safe swallowing strategies were reviewed. The note further identified a whole cinnamon roll on R8's tray had not been cut up and R8 declined to eat it. R8's lunch tray ticket dated 5/11/26, identified R8's ordered diet was Regular – Dysphagia Advanced and	F0803		05/13/2026

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F0803 SS = D	Continued from page 5 included ground country fried steak with mushroom gravy, mashed potatoes, honey roasted carrots, dinner roll, and a chopped square of strawberry shortcake. The facility's "Mapping to International Dysphagia Diet Standardization Initiative (IDDSI) Foods" form, copyright December 2017, identified the following food texture crosswalks: Regular diet corresponded with IDDSI Level 7 – Regular; Dysphagia Advanced corresponded with IDDSI Level 6 – Soft and Bite-Sized; Dysphagia Mechanically Altered corresponded with IDDSI Level 5 – Minced and Moist; Dysphagia Pureed corresponded with IDDSI Level 4 – Pureed; and Dysphagia Liquidized corresponded with IDDSI Level 3 – Liquidised. Facility form, "(IDDSI) Level 6 Soft and Bite-Sized guidance for adults," identified foods were to be soft, tender, and moist with no thin liquid leaking or dripping from the food. The guidance further identified bite-sized pieces were to be no bigger than 1.5 cm x 1.5 cm, food was to be able to be mashed or broken down with pressure from a fork, and the texture level was intended to reduce choking risk. Vegetables served under this texture level were to be steamed or boiled until soft throughout, and regular or dry bread products were not recommended. During an observation and interview on 5/11/26 at 1:40 p.m., nursing assistant (NA)-A delivered R8's lunch tray to R8 while R8 was seated upright in a recliner in her room. The tray ticket identified an advanced dysphagia diet with NDD3 textures and ground meat. Foods observed on the tray included ground country fried steak with gravy, mashed potatoes, and honey roasted carrots. At 1:43 p.m., the carrots were observed to be whole, circular, crinkle-cut slices. When asked if the carrots were the correct texture for R8's diet, NA-A stated, "I am not sure but she has had to wait for her lunch she is hungry and wants to eat now." R8 stated, "I can eat them." Surveyor instructed NA-A to hold the carrots until the diet texture could be confirmed with nurse manager (NM)-A. At 1:45 p.m., NM-A observed the carrots and stated they were not appropriate for R8's diet because they were not cut up. NM-A attempted to mash the carrots with a fork and was unable to do so, stating they were undercooked and "way too hard for her." NM-A further attempted to cut the carrots with the side of a fork and was unable to do so. NM-A removed the carrots from R8's plate and stated R8 could eat the remainder of the meal while replacement carrots were obtained. NM-A measured one carrot slice and stated it	F0803		05/13/2026

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F0803 SS = D	Continued from page 6 measured approximately 1.2 inches side-to-side and should have been smaller bite-sized pieces. NM-A stated, “The carrots were not easily mashable with a fork and could have caused her to choke because she has dysphagia.” During an observation and interview on 5/11/26 at 1:59 p.m., cook (C)-A observed R8’s carrots and stated for an NDD3 diet she would steam carrots and cut them into pieces and would not serve carrot slices like those observed because they were too large and could cause choking. During an interview on 5/11/26 at 2:58 p.m., the director of nursing (DON) stated R8’s diet order was NDD Level 3 textures with ground meat. After being informed how R8’s carrots were served during the lunch meal, the DON stated the carrots should have been well cooked and easily mashable with a fork. The DON further stated the expectation was residents with dysphagia be served the correct texture diet to prevent choking. During an interview on 5/11/26 at 3:28 p.m., the speech language pathologist (SLP) stated R8 recently experienced a choking incident, and she was asked to assess the resident. SLP stated R8 was experiencing dysphagia, and she recommended an NDD Level 3 texture diet with ground meat. After being informed R8’s lunch tray included ground meat with gravy, mashed potatoes, and circular crinkle-cut carrots that could not be cut or softened with a fork and one carrot measured 1.2 inches side-to-side, the SLP stated the carrots should have been thoroughly cooked and fork mashable. The SLP stated a core requirement of the diet was vegetables must be fork mashable and if the food could not easily be squashed with a fork, it was too firm for the resident to safely chew and swallow. The SLP further stated food should be bite-sized and no larger than the width of a fork because large crinkle-cut or round slices could easily block an airway if swallowed whole. The SLP further stated during breakfast observation R8 was served a cinnamon roll which she removed from the tray because it should have been moistened with milk and cut into bite-sized pieces. The SLP stated when the wrong texture diet was provided to R8, it placed the resident at risk for choking, aspiration, and death. During a phone interview on 5/11/26 at 3:36 p.m., the dietician stated according to the national dysphagia diet textures foods should be fork mashable. The dietician stated she would further check the requirements. A follow up phone interview	F0803		05/13/2026

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F0803 SS = D	Continued from page 7 at 4:04 p.m., the dietician stated there were no measurement requirements for an NDD Level 3 diet. The dietician further stated vegetables for an NDD Level 3 diet should be soft, well cooked, and chopped if needed. Facility policy “Therapeutic Diet Orders” dated October 2023, identified the facility was to provide residents with foods in the appropriate form and/or appropriate nutritive content as prescribed by a physician and/or assessed by the interdisciplinary team to support the resident’s treatment plan and goals. The policy defined a mechanically altered diet as one in which the texture or consistency of food is altered to facilitate oral intake and identified examples including soft solids, pureed foods, ground meat, and thickened liquids. The policy further identified dietary and nursing staff were responsible for providing therapeutic diets in the appropriate form and/or appropriate nutritive content as prescribed.	F0803		05/13/2026

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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 5/11/26, an onsite revisit was conducted to follow up on deficiencies issued related to a licensing survey exited on 4/13/26, by the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure. The original licensing order issued will remain in effect, and a penalty assessment was issued. The complaint H51841114C (254988007, 254996007, 255002009, and 255090002) which was found to be out of compliance and issued at F803 at the time of the survey, remained out of compliance.	20000		05/18/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/11/2026**

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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		05/18/2026
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as	20830	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: CNA provided immediate education on ensuring the diet provided matches the tray ticket prior to serving the meal by UM on 5/11/2026. Cook was placed on suspension pending investigation on 5/11/2026 and was termed from employment. Dietary manager was provided education on	05/13/2026

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20830	Continued from page 2 evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 3 residents (R8) with physician-ordered dysphagia precautions received food prepared and served in the correct texture consistency according to the resident's prescribed diet, placing the resident at risk for choking and/or aspiration. Findings include: R8's face sheet printed 5/11/26, identified diagnoses of dysphagia, oropharyngeal phase, cerebrovascular disease, and gastroesophageal reflux disease (GERD). R8's annual minimum data set (MDS) dated 2/28/26, identified R8's cognition was intact, required setup or clean-up assist with eating. R8's care area assessment (CAA) dated 2/28/26, identified the nutritional CAA triggered secondary to swallowing issues, mechanically altered diet, and dysphagia. Risk factors identified included aspiration. The CAA identified a care plan would be maintained and/or initiated to improve or maintain dietary and hydration status and monitor dietary and fluid intake. R8's care plan revised 12/3/25, identified a focus of ADL self-care deficit related to osteoarthritis, neuropathy, essential tremors, and obesity. Interventions revised 5/7/26 identified staff were to provide eating assistance including direct assist with meals, general supervision if eating in the dining room, and 1:1 intake assistance for practice of safe swallowing strategies and feeding. R8's care plan revised 4/27/26, identified a focus of obesity (Class II) related to greater energy input versus output as evidenced by a BMI of 36.3 per charting and the need for regular nutritional intake and weight monitoring. Interventions revised 5/7/26 identified staff were to provide diet as ordered: Level 3 advanced texture with ground meat and thin/regular liquid consistency. R8's comprehensive nutritional assessment dated 4/25/26, identified chewing and swallowing problems. The assessment further identified the resident experienced swallowing issues with medications during hospitalization and medications were administered one at a time in pudding or oatmeal to promote safe swallowing.	20830	Continued from page 2 ensuring dietary staff provided meals per MD orders and menu by Regional HCSG Director of Operations on 5/12/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents on a mechanically altered diet have the potential to be affected. An audit was completed of tray tickets to ensure they match the dietary orders, and any extraneous items are removed from tray tickets by the dietary manager on 5/12/2026 Progress notes for past 30 days were reviewed to ensure there were no other "choking" incidents documented on 5/12/2026 by DON with no other incidents What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur; and: Education with nurses/CNAs/direct care staff on the mechanically altered diet policy, diet consistency/textures, verifying diet accuracy prior to serving meals, supervision during meals, and change in condition assessment 5/12/2026 with any staff receiving education by 5/13/2026 not being allowed to work until receiving education. Huddles will be held by the floor nurse at the start of each shift to pass along any changes in resident condition or orders. Speech communication will include verification of what specific supervision is needed for those with altered diets and will be verbally given to nursing staff, written on the Therapy Communication to Nursing form and updated/uploaded into residents Medical Record, Care Plan, and staff tasks to complete. All written speech communication forms will be reviewed daily Monday – Friday as part of the clinical morning meeting process to ensure Orders, Care Plan, Kardex have been updated to	05/13/2026

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20830	Continued from page 3 R8's Situation, Background, Assessment, Recommendation (SBAR)/progress note dated 5/2/26 at 11:12 p.m., identified R8 reported choking on a tater tot during the noon meal and stated, "I really thought I was going to die." R8 later reported swallowing was difficult at times and expressed she had been considering requesting her meat be chopped finely. R8 also reported feeling short of breath following the choking episode. R8's Nurse Practitioner recertification visit dated 5/4/26, identified nursing reported an episode of aspiration the previous day. The note further identified R8 had continued to tolerate oral intake well and staff were questioning whether food alterations would be necessary. New orders identified speech therapy was to evaluate and treat R8. R8's Speech Therapy Evaluation and Plan of Treatment dated 5/5/26, identified R8 was referred for skilled speech therapy services due to a recent choking incident and difficulty swallowing. The evaluation identified R8 had been receiving regular textures and thin liquids with meal assistance due to decreased self-feeding abilities. The evaluation further identified weakness with oral musculature and mild clinical signs and symptoms of dysphagia with regular textures. Recommendations included NDD3 textures due to recent choking incident and oropharyngeal dysphagia, ground meat per resident preference, medications in puree, and 1:1 assistance for all meals to practice safe swallowing strategies and feeding due to physical deficits. Recommended compensatory strategies included small bites and sips, slow rate, alternating bites and sips, sitting upright for all intake, and 1:1 assistance/supervision. R8's Speech Therapy Treatment Encounter note dated 5/5/26 at 11:50 a.m., identified weakness with oral musculature and recommendations for NDD3 textures due to a recent choking incident and oropharyngeal dysphagia, including ground meat per resident preference and medications in puree. The note further identified R8 required 1:1 assistance for all meals to practice safe swallowing strategies and feeding due to physical deficits. Safe swallowing strategies reviewed with R8 included small bites and sips, slow rate, alternating bites and sips, and sitting upright during meals. R8's Therapy Communication to Nursing form dated 5/5/26, identified R8 was to receive NDD3 textures with ground meat and medications in applesauce. The form further identified staff were to provide 1:1	20830	Continued from page 3 reflect the appropriate diet and supervision requirements of the residents. Any communication slips generated after hours will be addressed the following morning in our clinical stand-up meeting, and any changes over the weekend will be reviewed on Monday morning. Nurse on call will be notified of any changes in orders; nurse on call will communicate with staff and implement the changes as needed. Nurse on call 24/7. A nurse will be present in the dining room for meals to ensure appropriate diets are served, and to help monitor any choking incidents, to assist in providing general supervision of residents' dining in the dining room per the recommendations from speech therapy Residents requiring direct supervision during meals and preferring to eat in their room will have a staff member present to provide direct supervision during meals per the recommendations from speech therapy Video education followed by a written test was initiated by dietary manager with dietary cooks, dietary aides and activities staff on 5/12/2026 on diet consistency/textures and serving the appropriate diet per tray ticket with any staff not receiving education by 5/13/2026 not being allowed to work until education is completed. All altered diets will be checked by cook preparing the meal and then re-checked by dietary aide/dietary manager/designee before it leaves the kitchen to ensure food is prepared and served per the diet order. Dietary audits will be completed on all trays for all meals of high-risk residents daily x 6 days to ensure diet matches the dietary orders, 5 trays of high risk residents per week x 3 weeks to ensure diet matches the dietary order, then 3 trays of high risk residents per week x 1 week to ensure diet matches the dietary order and/or until substantial compliance is maintained and finding with be reviewed in QAPI monthly Nursing audits will be completed 5/week during mealtimes x 4 weeks to ensure appropriate diets are provided per the MD	05/13/2026

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20830	Continued from page 4 assistance for practice of safe swallowing strategies and feeding and that R8 could have general supervision if eating in the dining room. R8's Nutrition/Dietary note dated 5/5/26 at 3:48 p.m., identified speech language pathology (SLP) recommendations for National Dysphagia Diet Level 3 (NDD3) textures with ground meat. The note further identified staff were to update Meal Tracker and monitor and follow up as needed. R8's Speech Therapy Treatment Encounter note dated 5/6/26 at 11:24 a.m., identified SLP interventions to optimize oropharyngeal swallow functioning, including review of safe swallowing strategies. The note identified R8 reported staff had been assisting her with meals for a "long time" and staff were to provide assistance with meals. The note further identified R8 was encouraged to remain upright and get into her wheelchair for every meal to support safe swallowing practices. R8's SBAR/Change of Condition note dated 5/6/26 at 6:54 p.m., identified R8 had a coughing episode during the dinner meal and was having difficulty with thin liquids. The note further identified R8 was eating jellybeans in her room and asking for popcorn. Recommendations identified staff requested evaluation and further advisement. R8's verbal diet order dated 5/7/26 at 8:16 a.m., identified R8's ordered diet was Regular diet with Level 3 advanced texture, thin/regular liquid consistency, and ground meat. R8's Order Summary report printed 5/11/26, identified an active dietary order dated and started 5/7/26 for a regular diet with Level 3 advanced texture, thin/regular liquid consistency, and ground meat. R8's Speech Therapy Treatment Encounter note dated 5/7/26 at 12:08 p.m., identified SLP interventions to optimize airway protection and bolus efficiency. The note identified nursing aides had assisted R8 with breakfast and R8 demonstrated carryover of safe swallowing strategies, stating staff were giving "slow, small bites." The note further identified R8 required maximum hand-over-hand assistance to bring a cup to her mouth independently and demonstrated light coughing following two small sips of water. Continued recommendations included 1:1 assistance with meals for feeding and implementation of safe swallowing strategies due to dysphagia, recent choking incident, cerebrovascular disease, and	20830	Continued from page 4 order and appropriate supervision is in place during dining and/or until substantial compliance is maintained and findings are reviewed in QAPI monthly Any non-compliance by staff in this process will lead to immediate education. Trays will be returned to dietary to be reviewed for accuracy and corrected if/as needed. Continued non-compliance will result in disciplinary action including suspension and up to potential termination. Describe the Quality Assurance and Process Improvement Program that will be put into place. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/13/2026	05/13/2026

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20830	Continued from page 5 physical limitations. R8's Speech Therapy Treatment Encounter note dated 5/10/26 at 3:19 p.m., identified SLP interventions and compensatory strategies to optimize oropharyngeal swallow functioning. The note identified meals had been "going better" since diet changes to NDD3 with ground meat and medications administered in puree. The note further identified R8 recalled staff providing meal assistance and practicing safe swallowing strategies, and ongoing 1:1 assistance was required for feeding due to a history of choking and dysphagia. R8's Kardex printed 5/11/26, identified staff were to provide direct assistance with meals, with 1:1 intake assistance for practice of safe swallowing strategies and feeding. The Kardex further identified R8's ordered diet was Level 3 advanced texture with ground meat and thin/regular liquid consistency. R8's breakfast tray ticket dated 5/11/26, identified R8's ordered diet was Regular – Dysphagia Advanced and included ground sausage patty and a glazed cinnamon roll. The tray ticket further identified weighted/built-up silverware, and a scoop plate were to be provided. R8's Speech Therapy Treatment Encounter note dated 5/11/26 at 11:12 a.m., identified SLP interventions and compensatory strategies to optimize airway protection and swallow efficiency during breakfast. The note identified R8 was dependent on staff for bringing all food and liquids to her mouth and safe swallowing strategies were reviewed. The note further identified a whole cinnamon roll on R8's tray had not been cut up and R8 declined to eat it. R8's lunch tray ticket dated 5/11/26, identified R8's ordered diet was Regular – Dysphagia Advanced and included ground country fried steak with mushroom gravy, mashed potatoes, honey roasted carrots, dinner roll, and a chopped square of strawberry shortcake. The facility's "Mapping to International Dysphagia Diet Standardization Initiative (IDDSI) Foods" form, copyright December 2017, identified the following food texture crosswalks: Regular diet corresponded with IDDSI Level 7 – Regular; Dysphagia Advanced corresponded with IDDSI Level 6 – Soft and Bite-Sized; Dysphagia Mechanically Altered corresponded with IDDSI Level 5 – Minced and Moist; Dysphagia Pureed corresponded with IDDSI Level 4 – Pureed; and Dysphagia Liquidized	20830		05/13/2026

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20830	Continued from page 6 corresponded with IDDSI Level 3 – Liquidised. Facility form, “(IDDSI) Level 6 Soft and Bite-Sized guidance for adults,” identified foods were to be soft, tender, and moist with no thin liquid leaking or dripping from the food. The guidance further identified bite-sized pieces were to be no bigger than 1.5 cm x 1.5 cm, food was to be able to be mashed or broken down with pressure from a fork, and the texture level was intended to reduce choking risk. Vegetables served under this texture level were to be steamed or boiled until soft throughout, and regular or dry bread products were not recommended. During an observation and interview on 5/11/26 at 1:40 p.m., nursing assistant (NA)-A delivered R8’s lunch tray to R8 while R8 was seated upright in a recliner in her room. The tray ticket identified an advanced dysphagia diet with NDD3 textures and ground meat. Foods observed on the tray included ground country fried steak with gravy, mashed potatoes, and honey roasted carrots. At 1:43 p.m., the carrots were observed to be whole, circular, crinkle-cut slices. When asked if the carrots were the correct texture for R8’s diet, NA-A stated, “I am not sure but she has had to wait for her lunch she is hungry and wants to eat now.” R8 stated, “I can eat them.” Surveyor instructed NA-A to hold the carrots until the diet texture could be confirmed with nurse manager (NM)-A. At 1:45 p.m., NM-A observed the carrots and stated they were not appropriate for R8’s diet because they were not cut up. NM-A attempted to mash the carrots with a fork and was unable to do so, stating they were undercooked and “way too hard for her.” NM-A further attempted to cut the carrots with the side of a fork and was unable to do so. NM-A removed the carrots from R8’s plate and stated R8 could eat the remainder of the meal while replacement carrots were obtained. NM-A measured one carrot slice and stated it measured approximately 1.2 inches side-to-side and should have been smaller bite-sized pieces. NM-A stated, “The carrots were not easily mashable with a fork and could have caused her to choke because she has dysphagia.” During an observation and interview on 5/11/26 at 1:59 p.m., cook (C)-A observed R8’s carrots and stated for an NDD3 diet she would steam carrots and cut them into pieces and would not serve carrot slices like those observed because they were too large and could cause choking. During an interview on 5/11/26 at 2:58 p.m., the director of nursing (DON) stated R8’s diet order was	20830		05/13/2026

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20830	Continued from page 7 NDD Level 3 textures with ground meat. After being informed how R8's carrots were served during the lunch meal, the DON stated the carrots should have been well cooked and easily mashable with a fork. The DON further stated the expectation was residents with dysphagia be served the correct texture diet to prevent choking. During an interview on 5/11/26 at 3:28 p.m., the speech language pathologist (SLP) stated R8 recently experienced a choking incident, and she was asked to assess the resident. SLP stated R8 was experiencing dysphagia, and she recommended an NDD Level 3 texture diet with ground meat. After being informed R8's lunch tray included ground meat with gravy, mashed potatoes, and circular crinkle-cut carrots that could not be cut or softened with a fork and one carrot measured 1.2 inches side-to-side, the SLP stated the carrots should have been thoroughly cooked and fork mashable. The SLP stated a core requirement of the diet was vegetables must be fork mashable and if the food could not easily be squashed with a fork, it was too firm for the resident to safely chew and swallow. The SLP further stated food should be bite-sized and no larger than the width of a fork because large crinkle-cut or round slices could easily block an airway if swallowed whole. The SLP further stated during breakfast observation R8 was served a cinnamon roll which she removed from the tray because it should have been moistened with milk and cut into bite-sized pieces. The SLP stated when the wrong texture diet was provided to R8, it placed the resident at risk for choking, aspiration, and death. During a phone interview on 5/11/26 at 3:36 p.m., the dietician stated according to the national dysphagia diet textures foods should be fork mashable. The dietician stated she would further check the requirements. A follow up phone interview at 4:04 p.m., the dietician stated there were no measurement requirements for an NDD Level 3 diet. The dietician further stated vegetables for an NDD Level 3 diet should be soft, well cooked, and chopped if needed. Facility policy "Therapeutic Diet Orders" dated October 2023, identified the facility was to provide residents with foods in the appropriate form and/or appropriate nutritive content as prescribed by a physician and/or assessed by the interdisciplinary team to support the resident's treatment plan and goals. The policy defined a mechanically altered diet as one in which the texture or consistency of food is altered to facilitate oral intake and identified	20830		05/13/2026

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20830	Continued from page 8 examples including soft solids, pureed foods, ground meat, and thickened liquids. The policy further identified dietary and nursing staff were responsible for providing therapeutic diets in the appropriate form and/or appropriate nutritive content as prescribed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), dietary manager, speech language pathologist (SLP), or designee could review and/or revise facility policies and procedures related to dysphagia management and therapeutic food texture consistency. The facility could provide education and competency validation for nursing and dietary staff regarding implementation of prescribed dysphagia diets and appropriate food textures according to physician orders and facility guidelines. The facility could implement a monitoring system including meal observations and tray audits to ensure residents receive the correct food texture consistency as ordered. The DON, dietary manager, SLP, or designee could report findings, corrective actions, and ongoing monitoring results to the Quality Assurance Performance Improvement (QAPI) committee for a determined period of time until compliance is achieved and maintained. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		05/13/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 29, 2026

Administrator
Rochester Restorative Care Center
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: March 12, 2026

Dear Administrator:

On April 8, 2026, we informed you that we may impose enforcement remedies.

On April 13, 2026, the Minnesota Department of Health completed a survey, and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety.

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

At the time of this survey, we identified the following deficiency:

F0803: Menus Meet Resident Needs/Prep in Adv/Followed

REMOVAL OF IMMEDIATE JEOPARDY

On April 11, 2026, the situation of immediate jeopardy to potential health and safety cited at F803 was removed, however, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 14, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 14, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 14, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 14, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Rochester Restorative Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 14, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for

new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 12, 2026, if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file

electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

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.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 29, 2026

Administrator
Rochester Restorative Care Center
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: State Nursing Home Licensing Orders
Event ID: 22D6D9-H1

Dear Administrator:

The above facility survey was completed on April 13, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Restorative Care Center	**501 EIGHTH AVENUE SOUTHEAST , ROCHESTER, Minnesota, 55904**

(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
F0000	INITIAL COMMENTS On 5/11/26, an onsite revisit was conducted to follow up on deficiencies related to an abbreviated survey exited on 4/13/26. The facility was NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. H51841114C (254988007, 254996007, 255002009, 255090002), remained NOT IN COMPLIANCE and reissued at F803. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		05/15/2026
F0803 SS = D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received	F0803	F803 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: CNA provided immediate education on ensuring the diet provided matches the tray ticket prior to serving the meal by UM on 5/11/2026. Cook was placed on suspension pending investigation on 5/11/2026 and was termed from employment. Dietary manager was provided education on ensuring dietary staff provided meals per MD orders and menu by Regional HCSG Director of Operations on 5/12/2026	05/13/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/11/2026

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F0803 SS = D	Continued from page 1 from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 3 residents (R8) with physician-ordered dysphagia precautions received food prepared and served in the correct texture consistency according to the resident's prescribed diet, placing the resident at risk for choking and/or aspiration. Findings include: R8's face sheet printed 5/11/26, identified diagnoses of dysphagia, oropharyngeal phase, cerebrovascular disease, and gastroesophageal reflux disease (GERD). R8's annual minimum data set (MDS) dated 2/28/26, identified R8's cognition was intact, required setup or clean-up assist with eating. R8's care area assessment (CAA) dated 2/28/26, identified the nutritional CAA triggered secondary to swallowing issues, mechanically altered diet, and dysphagia. Risk factors identified included aspiration. The CAA identified a care plan would be maintained and/or initiated to improve or maintain dietary and hydration status and monitor dietary and fluid intake. R8's care plan revised 12/3/25, identified a focus of ADL self-care deficit related to osteoarthritis, neuropathy, essential tremors, and obesity. Interventions revised 5/7/26 identified staff were to provide eating assistance including direct assist with meals, general supervision if eating in the dining room, and 1:1 intake assistance for practice of safe swallowing strategies and feeding. R8's care plan revised 4/27/26, identified a focus of obesity (Class II) related to greater energy input	F0803	Continued from page 1 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents on a mechanically altered diet have the potential to be affected. An audit was completed of tray tickets to ensure they match dietary orders, and any extraneous items are removed from tray tickets by the dietary manager on 5/12/2026 Progress notes for past 30 days were reviewed to ensure there were no other "choking" incidents documented on 5/12/2026 by DON with no other incidents What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur; and: Education with nurses/CNAs/direct care staff on the mechanically altered diet policy, diet consistency/textures, verifying diet accuracy prior to serving meals, supervision during meals, and change in condition assessment 5/12/2026 with any staff receiving education by 5/13/2026 not being allowed to work until receiving education. Huddles will be held by the floor nurse at the start of each shift to pass along any changes in resident condition or orders. Speech communication will include verification of what specific supervision is needed for those with altered diets and will be verbally given to nursing staff, written on the Therapy Communication to Nursing form and updated/uploaded into residents Medical Record, Care Plan, and staff tasks to complete. All written speech communication forms will be reviewed daily Monday – Friday as part of the clinical morning meeting process to ensure Orders, Care Plan, Kardex have been updated to reflect the appropriate diet and supervision requirements of the residents. Any communication slips generated after hours will be addressed the following morning in our clinical stand-up meeting, and any changes over the	05/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/11/2026

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F0803 SS = D	Continued from page 2 versus output as evidenced by a BMI of 36.3 per charting and the need for regular nutritional intake and weight monitoring. Interventions revised 5/7/26 identified staff were to provide diet as ordered: Level 3 advanced texture with ground meat and thin/regular liquid consistency. R8's comprehensive nutritional assessment dated 4/25/26, identified chewing and swallowing problems. The assessment further identified the resident experienced swallowing issues with medications during hospitalization and medications were administered one at a time in pudding or oatmeal to promote safe swallowing. R8's Situation, Background, Assessment, Recommendation (SBAR)/progress note dated 5/2/26 at 11:12 p.m., identified R8 reported choking on a tater tot during the noon meal and stated, "I really thought I was going to die." R8 later reported swallowing was difficult at times and expressed she had been considering requesting her meat be chopped finely. R8 also reported feeling short of breath following the choking episode. R8's Nurse Practitioner recertification visit dated 5/4/26, identified nursing reported an episode of aspiration the previous day. The note further identified R8 had continued to tolerate oral intake well and staff were questioning whether food alterations would be necessary. New orders identified speech therapy was to evaluate and treat R8. R8's Speech Therapy Evaluation and Plan of Treatment dated 5/5/26, identified R8 was referred for skilled speech therapy services due to a recent choking incident and difficulty swallowing. The evaluation identified R8 had been receiving regular textures and thin liquids with meal assistance due to decreased self-feeding abilities. The evaluation further identified weakness with oral musculature and mild clinical signs and symptoms of dysphagia with regular textures. Recommendations included NDD3 textures due to recent choking incident and oropharyngeal dysphagia, ground meat per resident preference, medications in puree, and 1:1 assistance for all meals to practice safe swallowing strategies and feeding due to physical deficits. Recommended compensatory strategies included small bites and sips, slow rate, alternating bites and sips, sitting upright for all intake, and 1:1 assistance/supervision. R8's Speech Therapy Treatment Encounter note dated 5/5/26 at 11:50 a.m., identified weakness with	F0803	Continued from page 2 weekend will be reviewed on Monday morning. Nurse on call will be notified of any changes in orders; nurse on call will communicate with staff and implement the changes as needed. Nurse on call 24/7. A nurse will be present in the dining room for meals to ensure appropriate diets are served, and to help monitor any choking incidents, to assist in providing general supervision of residents' dining in the dining room per the recommendations from speech therapy Residents requiring direct supervision during meals and preferring to eat in their room will have a staff member present to provide direct supervision during meals per the recommendations from speech therapy Video education followed by a written test was initiated by dietary manager with dietary cooks, dietary aides and activities staff on 5/12/2026 on diet consistency/textures and serving the appropriate diet per tray ticket with any staff not receiving education by 5/13/2026 not being allowed to work until education is completed. All altered diets will be checked by cook preparing the meal and then re-checked by dietary aide/dietary manager/designee before it leaves the kitchen to ensure food is prepared and served per the diet order. Dietary audits will be completed on all trays for all meals of high-risk residents daily x 6 days to ensure diet matches the dietary orders, 5 trays of high risk residents per week x 3 weeks to ensure diet matches the dietary order, then 3 trays of high risk residents per week x 1 week to ensure diet matches the dietary order and/or until substantial compliance is maintained and finding with be reviewed in QAPI monthly Nursing audits will be completed 5/week during mealtimes x 4 weeks to ensure appropriate diets are provided per the MD order and appropriate supervision is in place during dining and/or until substantial compliance is maintained and findings are reviewed in QAPI monthly Any non-compliance by staff in this process will lead to immediate education. Trays will be returned	05/13/2026

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F0803 SS = D	Continued from page 3 oral musculature and recommendations for NDD3 textures due to a recent choking incident and oropharyngeal dysphagia, including ground meat per resident preference and medications in puree. The note further identified R8 required 1:1 assistance for all meals to practice safe swallowing strategies and feeding due to physical deficits. Safe swallowing strategies reviewed with R8 included small bites and sips, slow rate, alternating bites and sips, and sitting upright during meals. R8's Therapy Communication to Nursing form dated 5/5/26, identified R8 was to receive NDD3 textures with ground meat and medications in applesauce. The form further identified staff were to provide 1:1 assistance for practice of safe swallowing strategies and feeding and that R8 could have general supervision if eating in the dining room. R8's Nutrition/Dietary note dated 5/5/26 at 3:48 p.m., identified speech language pathology (SLP) recommendations for National Dysphagia Diet Level 3 (NDD3) textures with ground meat. The note further identified staff were to update Meal Tracker and monitor and follow up as needed. R8's Speech Therapy Treatment Encounter note dated 5/6/26 at 11:24 a.m., identified SLP interventions to optimize oropharyngeal swallow functioning, including review of safe swallowing strategies. The note identified R8 reported staff had been assisting her with meals for a "long time" and staff were to provide assistance with meals. The note further identified R8 was encouraged to remain upright and get into her wheelchair for every meal to support safe swallowing practices. R8's SBAR/Change of Condition note dated 5/6/26 at 6:54 p.m., identified R8 had a coughing episode during the dinner meal and was having difficulty with thin liquids. The note further identified R8 was eating jellybeans in her room and asking for popcorn. Recommendations identified staff requested evaluation and further advisement. R8's verbal diet order dated 5/7/26 at 8:16 a.m., identified R8's ordered diet was Regular diet with Level 3 advanced texture, thin/regular liquid consistency, and ground meat. R8's Order Summary report printed 5/11/26, identified an active dietary order dated and started 5/7/26 for a regular diet with Level 3 advanced texture, thin/regular liquid consistency, and ground meat.	F0803	Continued from page 3 to dietary to be reviewed for accuracy and corrected if/as needed. Continued non-compliance will result in disciplinary action including suspension and up to potential termination. Describe the Quality Assurance and Process Improvement Program that will be put into place. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/13/2026	05/13/2026

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F0803 SS = D	Continued from page 4 R8's Speech Therapy Treatment Encounter note dated 5/7/26 at 12:08 p.m., identified SLP interventions to optimize airway protection and bolus efficiency. The note identified nursing aides had assisted R8 with breakfast and R8 demonstrated carryover of safe swallowing strategies, stating staff were giving "slow, small bites." The note further identified R8 required maximum hand-over-hand assistance to bring a cup to her mouth independently and demonstrated light coughing following two small sips of water. Continued recommendations included 1:1 assistance with meals for feeding and implementation of safe swallowing strategies due to dysphagia, recent choking incident, cerebrovascular disease, and physical limitations. R8's Speech Therapy Treatment Encounter note dated 5/10/26 at 3:19 p.m., identified SLP interventions and compensatory strategies to optimize oropharyngeal swallow functioning. The note identified meals had been "going better" since diet changes to NDD3 with ground meat and medications administered in puree. The note further identified R8 recalled staff providing meal assistance and practicing safe swallowing strategies, and ongoing 1:1 assistance was required for feeding due to a history of choking and dysphagia. R8's Kardex printed 5/11/26, identified staff were to provide direct assistance with meals, with 1:1 intake assistance for practice of safe swallowing strategies and feeding. The Kardex further identified R8's ordered diet was Level 3 advanced texture with ground meat and thin/regular liquid consistency. R8's breakfast tray ticket dated 5/11/26, identified R8's ordered diet was Regular – Dysphagia Advanced and included ground sausage patty and a glazed cinnamon roll. The tray ticket further identified weighted/built-up silverware, and a scoop plate were to be provided. R8's Speech Therapy Treatment Encounter note dated 5/11/26 at 11:12 a.m., identified SLP interventions and compensatory strategies to optimize airway protection and swallow efficiency during breakfast. The note identified R8 was dependent on staff for bringing all food and liquids to her mouth and safe swallowing strategies were reviewed. The note further identified a whole cinnamon roll on R8's tray had not been cut up and R8 declined to eat it. R8's lunch tray ticket dated 5/11/26, identified R8's ordered diet was Regular – Dysphagia Advanced and	F0803		05/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/11/2026

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Rochester Restorative Care Center	**501 EIGHTH AVENUE SOUTHEAST , ROCHESTER, Minnesota, 55904**

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F0803 SS = D	Continued from page 5 included ground country fried steak with mushroom gravy, mashed potatoes, honey roasted carrots, dinner roll, and a chopped square of strawberry shortcake. The facility's "Mapping to International Dysphagia Diet Standardization Initiative (IDDSI) Foods" form, copyright December 2017, identified the following food texture crosswalks: Regular diet corresponded with IDDSI Level 7 – Regular; Dysphagia Advanced corresponded with IDDSI Level 6 – Soft and Bite-Sized; Dysphagia Mechanically Altered corresponded with IDDSI Level 5 – Minced and Moist; Dysphagia Pureed corresponded with IDDSI Level 4 – Pureed; and Dysphagia Liquidized corresponded with IDDSI Level 3 – Liquidised. Facility form, "(IDDSI) Level 6 Soft and Bite-Sized guidance for adults," identified foods were to be soft, tender, and moist with no thin liquid leaking or dripping from the food. The guidance further identified bite-sized pieces were to be no bigger than 1.5 cm x 1.5 cm, food was to be able to be mashed or broken down with pressure from a fork, and the texture level was intended to reduce choking risk. Vegetables served under this texture level were to be steamed or boiled until soft throughout, and regular or dry bread products were not recommended. During an observation and interview on 5/11/26 at 1:40 p.m., nursing assistant (NA)-A delivered R8's lunch tray to R8 while R8 was seated upright in a recliner in her room. The tray ticket identified an advanced dysphagia diet with NDD3 textures and ground meat. Foods observed on the tray included ground country fried steak with gravy, mashed potatoes, and honey roasted carrots. At 1:43 p.m., the carrots were observed to be whole, circular, crinkle-cut slices. When asked if the carrots were the correct texture for R8's diet, NA-A stated, "I am not sure but she has had to wait for her lunch she is hungry and wants to eat now." R8 stated, "I can eat them." Surveyor instructed NA-A to hold the carrots until the diet texture could be confirmed with nurse manager (NM)-A. At 1:45 p.m., NM-A observed the carrots and stated they were not appropriate for R8's diet because they were not cut up. NM-A attempted to mash the carrots with a fork and was unable to do so, stating they were undercooked and "way too hard for her." NM-A further attempted to cut the carrots with the side of a fork and was unable to do so. NM-A removed the carrots from R8's plate and stated R8 could eat the remainder of the meal while replacement carrots were obtained. NM-A measured one carrot slice and stated it	F0803		05/13/2026

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F0803 SS = D	Continued from page 6 measured approximately 1.2 inches side-to-side and should have been smaller bite-sized pieces. NM-A stated, “The carrots were not easily mashable with a fork and could have caused her to choke because she has dysphagia.” During an observation and interview on 5/11/26 at 1:59 p.m., cook (C)-A observed R8’s carrots and stated for an NDD3 diet she would steam carrots and cut them into pieces and would not serve carrot slices like those observed because they were too large and could cause choking. During an interview on 5/11/26 at 2:58 p.m., the director of nursing (DON) stated R8’s diet order was NDD Level 3 textures with ground meat. After being informed how R8’s carrots were served during the lunch meal, the DON stated the carrots should have been well cooked and easily mashable with a fork. The DON further stated the expectation was residents with dysphagia be served the correct texture diet to prevent choking. During an interview on 5/11/26 at 3:28 p.m., the speech language pathologist (SLP) stated R8 recently experienced a choking incident, and she was asked to assess the resident. SLP stated R8 was experiencing dysphagia, and she recommended an NDD Level 3 texture diet with ground meat. After being informed R8’s lunch tray included ground meat with gravy, mashed potatoes, and circular crinkle-cut carrots that could not be cut or softened with a fork and one carrot measured 1.2 inches side-to-side, the SLP stated the carrots should have been thoroughly cooked and fork mashable. The SLP stated a core requirement of the diet was vegetables must be fork mashable and if the food could not easily be squashed with a fork, it was too firm for the resident to safely chew and swallow. The SLP further stated food should be bite-sized and no larger than the width of a fork because large crinkle-cut or round slices could easily block an airway if swallowed whole. The SLP further stated during breakfast observation R8 was served a cinnamon roll which she removed from the tray because it should have been moistened with milk and cut into bite-sized pieces. The SLP stated when the wrong texture diet was provided to R8, it placed the resident at risk for choking, aspiration, and death. During a phone interview on 5/11/26 at 3:36 p.m., the dietician stated according to the national dysphagia diet textures foods should be fork mashable. The dietician stated she would further check the requirements. A follow up phone interview	F0803		05/13/2026

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F0803 SS = D	Continued from page 7 at 4:04 p.m., the dietician stated there were no measurement requirements for an NDD Level 3 diet. The dietician further stated vegetables for an NDD Level 3 diet should be soft, well cooked, and chopped if needed. Facility policy “Therapeutic Diet Orders” dated October 2023, identified the facility was to provide residents with foods in the appropriate form and/or appropriate nutritive content as prescribed by a physician and/or assessed by the interdisciplinary team to support the resident’s treatment plan and goals. The policy defined a mechanically altered diet as one in which the texture or consistency of food is altered to facilitate oral intake and identified examples including soft solids, pureed foods, ground meat, and thickened liquids. The policy further identified dietary and nursing staff were responsible for providing therapeutic diets in the appropriate form and/or appropriate nutritive content as prescribed.	F0803		05/13/2026

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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 5/11/26, an onsite revisit was conducted to follow up on deficiencies issued related to a licensing survey exited on 4/13/26, by the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure. The original licensing order issued will remain in effect, and a penalty assessment was issued. The complaint H51841114C (254988007, 254996007, 255002009, and 255090002) which was found to be out of compliance and issued at F803 at the time of the survey, remained out of compliance.	20000		05/18/2026

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

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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		05/18/2026
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as	20830	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: CNA provided immediate education on ensuring the diet provided matches the tray ticket prior to serving the meal by UM on 5/11/2026. Cook was placed on suspension pending investigation on 5/11/2026 and was termed from employment. Dietary manager was provided education on	05/13/2026

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20830	Continued from page 2 evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 3 residents (R8) with physician-ordered dysphagia precautions received food prepared and served in the correct texture consistency according to the resident's prescribed diet, placing the resident at risk for choking and/or aspiration. Findings include: R8's face sheet printed 5/11/26, identified diagnoses of dysphagia, oropharyngeal phase, cerebrovascular disease, and gastroesophageal reflux disease (GERD). R8's annual minimum data set (MDS) dated 2/28/26, identified R8's cognition was intact, required setup or clean-up assist with eating. R8's care area assessment (CAA) dated 2/28/26, identified the nutritional CAA triggered secondary to swallowing issues, mechanically altered diet, and dysphagia. Risk factors identified included aspiration. The CAA identified a care plan would be maintained and/or initiated to improve or maintain dietary and hydration status and monitor dietary and fluid intake. R8's care plan revised 12/3/25, identified a focus of ADL self-care deficit related to osteoarthritis, neuropathy, essential tremors, and obesity. Interventions revised 5/7/26 identified staff were to provide eating assistance including direct assist with meals, general supervision if eating in the dining room, and 1:1 intake assistance for practice of safe swallowing strategies and feeding. R8's care plan revised 4/27/26, identified a focus of obesity (Class II) related to greater energy input versus output as evidenced by a BMI of 36.3 per charting and the need for regular nutritional intake and weight monitoring. Interventions revised 5/7/26 identified staff were to provide diet as ordered: Level 3 advanced texture with ground meat and thin/regular liquid consistency. R8's comprehensive nutritional assessment dated 4/25/26, identified chewing and swallowing problems. The assessment further identified the resident experienced swallowing issues with medications during hospitalization and medications were administered one at a time in pudding or oatmeal to promote safe swallowing.	20830	Continued from page 2 ensuring dietary staff provided meals per MD orders and menu by Regional HCSG Director of Operations on 5/12/2026 How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents on a mechanically altered diet have the potential to be affected. An audit was completed of tray tickets to ensure they match the dietary orders, and any extraneous items are removed from tray tickets by the dietary manager on 5/12/2026 Progress notes for past 30 days were reviewed to ensure there were no other "choking" incidents documented on 5/12/2026 by DON with no other incidents What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur; and: Education with nurses/CNAs/direct care staff on the mechanically altered diet policy, diet consistency/textures, verifying diet accuracy prior to serving meals, supervision during meals, and change in condition assessment 5/12/2026 with any staff receiving education by 5/13/2026 not being allowed to work until receiving education. Huddles will be held by the floor nurse at the start of each shift to pass along any changes in resident condition or orders. Speech communication will include verification of what specific supervision is needed for those with altered diets and will be verbally given to nursing staff, written on the Therapy Communication to Nursing form and updated/uploaded into residents Medical Record, Care Plan, and staff tasks to complete. All written speech communication forms will be reviewed daily Monday – Friday as part of the clinical morning meeting process to ensure Orders, Care Plan, Kardex have been updated to	05/13/2026

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20830	Continued from page 3 R8's Situation, Background, Assessment, Recommendation (SBAR)/progress note dated 5/2/26 at 11:12 p.m., identified R8 reported choking on a tater tot during the noon meal and stated, "I really thought I was going to die." R8 later reported swallowing was difficult at times and expressed she had been considering requesting her meat be chopped finely. R8 also reported feeling short of breath following the choking episode. R8's Nurse Practitioner recertification visit dated 5/4/26, identified nursing reported an episode of aspiration the previous day. The note further identified R8 had continued to tolerate oral intake well and staff were questioning whether food alterations would be necessary. New orders identified speech therapy was to evaluate and treat R8. R8's Speech Therapy Evaluation and Plan of Treatment dated 5/5/26, identified R8 was referred for skilled speech therapy services due to a recent choking incident and difficulty swallowing. The evaluation identified R8 had been receiving regular textures and thin liquids with meal assistance due to decreased self-feeding abilities. The evaluation further identified weakness with oral musculature and mild clinical signs and symptoms of dysphagia with regular textures. Recommendations included NDD3 textures due to recent choking incident and oropharyngeal dysphagia, ground meat per resident preference, medications in puree, and 1:1 assistance for all meals to practice safe swallowing strategies and feeding due to physical deficits. Recommended compensatory strategies included small bites and sips, slow rate, alternating bites and sips, sitting upright for all intake, and 1:1 assistance/supervision. R8's Speech Therapy Treatment Encounter note dated 5/5/26 at 11:50 a.m., identified weakness with oral musculature and recommendations for NDD3 textures due to a recent choking incident and oropharyngeal dysphagia, including ground meat per resident preference and medications in puree. The note further identified R8 required 1:1 assistance for all meals to practice safe swallowing strategies and feeding due to physical deficits. Safe swallowing strategies reviewed with R8 included small bites and sips, slow rate, alternating bites and sips, and sitting upright during meals. R8's Therapy Communication to Nursing form dated 5/5/26, identified R8 was to receive NDD3 textures with ground meat and medications in applesauce. The form further identified staff were to provide 1:1	20830	Continued from page 3 reflect the appropriate diet and supervision requirements of the residents. Any communication slips generated after hours will be addressed the following morning in our clinical stand-up meeting, and any changes over the weekend will be reviewed on Monday morning. Nurse on call will be notified of any changes in orders; nurse on call will communicate with staff and implement the changes as needed. Nurse on call 24/7. A nurse will be present in the dining room for meals to ensure appropriate diets are served, and to help monitor any choking incidents, to assist in providing general supervision of residents' dining in the dining room per the recommendations from speech therapy Residents requiring direct supervision during meals and preferring to eat in their room will have a staff member present to provide direct supervision during meals per the recommendations from speech therapy Video education followed by a written test was initiated by dietary manager with dietary cooks, dietary aides and activities staff on 5/12/2026 on diet consistency/textures and serving the appropriate diet per tray ticket with any staff not receiving education by 5/13/2026 not being allowed to work until education is completed. All altered diets will be checked by cook preparing the meal and then re-checked by dietary aide/dietary manager/designee before it leaves the kitchen to ensure food is prepared and served per the diet order. Dietary audits will be completed on all trays for all meals of high-risk residents daily x 6 days to ensure diet matches the dietary orders, 5 trays of high risk residents per week x 3 weeks to ensure diet matches the dietary order, then 3 trays of high risk residents per week x 1 week to ensure diet matches the dietary order and/or until substantial compliance is maintained and finding with be reviewed in QAPI monthly Nursing audits will be completed 5/week during mealtimes x 4 weeks to ensure appropriate diets are provided per the MD	05/13/2026

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20830	Continued from page 4 assistance for practice of safe swallowing strategies and feeding and that R8 could have general supervision if eating in the dining room. R8's Nutrition/Dietary note dated 5/5/26 at 3:48 p.m., identified speech language pathology (SLP) recommendations for National Dysphagia Diet Level 3 (NDD3) textures with ground meat. The note further identified staff were to update Meal Tracker and monitor and follow up as needed. R8's Speech Therapy Treatment Encounter note dated 5/6/26 at 11:24 a.m., identified SLP interventions to optimize oropharyngeal swallow functioning, including review of safe swallowing strategies. The note identified R8 reported staff had been assisting her with meals for a "long time" and staff were to provide assistance with meals. The note further identified R8 was encouraged to remain upright and get into her wheelchair for every meal to support safe swallowing practices. R8's SBAR/Change of Condition note dated 5/6/26 at 6:54 p.m., identified R8 had a coughing episode during the dinner meal and was having difficulty with thin liquids. The note further identified R8 was eating jellybeans in her room and asking for popcorn. Recommendations identified staff requested evaluation and further advisement. R8's verbal diet order dated 5/7/26 at 8:16 a.m., identified R8's ordered diet was Regular diet with Level 3 advanced texture, thin/regular liquid consistency, and ground meat. R8's Order Summary report printed 5/11/26, identified an active dietary order dated and started 5/7/26 for a regular diet with Level 3 advanced texture, thin/regular liquid consistency, and ground meat. R8's Speech Therapy Treatment Encounter note dated 5/7/26 at 12:08 p.m., identified SLP interventions to optimize airway protection and bolus efficiency. The note identified nursing aides had assisted R8 with breakfast and R8 demonstrated carryover of safe swallowing strategies, stating staff were giving "slow, small bites." The note further identified R8 required maximum hand-over-hand assistance to bring a cup to her mouth independently and demonstrated light coughing following two small sips of water. Continued recommendations included 1:1 assistance with meals for feeding and implementation of safe swallowing strategies due to dysphagia, recent choking incident, cerebrovascular disease, and	20830	Continued from page 4 order and appropriate supervision is in place during dining and/or until substantial compliance is maintained and findings are reviewed in QAPI monthly Any non-compliance by staff in this process will lead to immediate education. Trays will be returned to dietary to be reviewed for accuracy and corrected if/as needed. Continued non-compliance will result in disciplinary action including suspension and up to potential termination. Describe the Quality Assurance and Process Improvement Program that will be put into place. Results of audits will be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/13/2026	05/13/2026

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20830	Continued from page 5 physical limitations. R8's Speech Therapy Treatment Encounter note dated 5/10/26 at 3:19 p.m., identified SLP interventions and compensatory strategies to optimize oropharyngeal swallow functioning. The note identified meals had been "going better" since diet changes to NDD3 with ground meat and medications administered in puree. The note further identified R8 recalled staff providing meal assistance and practicing safe swallowing strategies, and ongoing 1:1 assistance was required for feeding due to a history of choking and dysphagia. R8's Kardex printed 5/11/26, identified staff were to provide direct assistance with meals, with 1:1 intake assistance for practice of safe swallowing strategies and feeding. The Kardex further identified R8's ordered diet was Level 3 advanced texture with ground meat and thin/regular liquid consistency. R8's breakfast tray ticket dated 5/11/26, identified R8's ordered diet was Regular – Dysphagia Advanced and included ground sausage patty and a glazed cinnamon roll. The tray ticket further identified weighted/built-up silverware, and a scoop plate were to be provided. R8's Speech Therapy Treatment Encounter note dated 5/11/26 at 11:12 a.m., identified SLP interventions and compensatory strategies to optimize airway protection and swallow efficiency during breakfast. The note identified R8 was dependent on staff for bringing all food and liquids to her mouth and safe swallowing strategies were reviewed. The note further identified a whole cinnamon roll on R8's tray had not been cut up and R8 declined to eat it. R8's lunch tray ticket dated 5/11/26, identified R8's ordered diet was Regular – Dysphagia Advanced and included ground country fried steak with mushroom gravy, mashed potatoes, honey roasted carrots, dinner roll, and a chopped square of strawberry shortcake. The facility's "Mapping to International Dysphagia Diet Standardization Initiative (IDDSI) Foods" form, copyright December 2017, identified the following food texture crosswalks: Regular diet corresponded with IDDSI Level 7 – Regular; Dysphagia Advanced corresponded with IDDSI Level 6 – Soft and Bite-Sized; Dysphagia Mechanically Altered corresponded with IDDSI Level 5 – Minced and Moist; Dysphagia Pureed corresponded with IDDSI Level 4 – Pureed; and Dysphagia Liquidized	20830		05/13/2026

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20830	Continued from page 6 corresponded with IDDSI Level 3 – Liquidised. Facility form, “(IDDSI) Level 6 Soft and Bite-Sized guidance for adults,” identified foods were to be soft, tender, and moist with no thin liquid leaking or dripping from the food. The guidance further identified bite-sized pieces were to be no bigger than 1.5 cm x 1.5 cm, food was to be able to be mashed or broken down with pressure from a fork, and the texture level was intended to reduce choking risk. Vegetables served under this texture level were to be steamed or boiled until soft throughout, and regular or dry bread products were not recommended. During an observation and interview on 5/11/26 at 1:40 p.m., nursing assistant (NA)-A delivered R8’s lunch tray to R8 while R8 was seated upright in a recliner in her room. The tray ticket identified an advanced dysphagia diet with NDD3 textures and ground meat. Foods observed on the tray included ground country fried steak with gravy, mashed potatoes, and honey roasted carrots. At 1:43 p.m., the carrots were observed to be whole, circular, crinkle-cut slices. When asked if the carrots were the correct texture for R8’s diet, NA-A stated, “I am not sure but she has had to wait for her lunch she is hungry and wants to eat now.” R8 stated, “I can eat them.” Surveyor instructed NA-A to hold the carrots until the diet texture could be confirmed with nurse manager (NM)-A. At 1:45 p.m., NM-A observed the carrots and stated they were not appropriate for R8’s diet because they were not cut up. NM-A attempted to mash the carrots with a fork and was unable to do so, stating they were undercooked and “way too hard for her.” NM-A further attempted to cut the carrots with the side of a fork and was unable to do so. NM-A removed the carrots from R8’s plate and stated R8 could eat the remainder of the meal while replacement carrots were obtained. NM-A measured one carrot slice and stated it measured approximately 1.2 inches side-to-side and should have been smaller bite-sized pieces. NM-A stated, “The carrots were not easily mashable with a fork and could have caused her to choke because she has dysphagia.” During an observation and interview on 5/11/26 at 1:59 p.m., cook (C)-A observed R8’s carrots and stated for an NDD3 diet she would steam carrots and cut them into pieces and would not serve carrot slices like those observed because they were too large and could cause choking. During an interview on 5/11/26 at 2:58 p.m., the director of nursing (DON) stated R8’s diet order was	20830		05/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/11/2026**

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20830	Continued from page 7 NDD Level 3 textures with ground meat. After being informed how R8's carrots were served during the lunch meal, the DON stated the carrots should have been well cooked and easily mashable with a fork. The DON further stated the expectation was residents with dysphagia be served the correct texture diet to prevent choking. During an interview on 5/11/26 at 3:28 p.m., the speech language pathologist (SLP) stated R8 recently experienced a choking incident, and she was asked to assess the resident. SLP stated R8 was experiencing dysphagia, and she recommended an NDD Level 3 texture diet with ground meat. After being informed R8's lunch tray included ground meat with gravy, mashed potatoes, and circular crinkle-cut carrots that could not be cut or softened with a fork and one carrot measured 1.2 inches side-to-side, the SLP stated the carrots should have been thoroughly cooked and fork mashable. The SLP stated a core requirement of the diet was vegetables must be fork mashable and if the food could not easily be squashed with a fork, it was too firm for the resident to safely chew and swallow. The SLP further stated food should be bite-sized and no larger than the width of a fork because large crinkle-cut or round slices could easily block an airway if swallowed whole. The SLP further stated during breakfast observation R8 was served a cinnamon roll which she removed from the tray because it should have been moistened with milk and cut into bite-sized pieces. The SLP stated when the wrong texture diet was provided to R8, it placed the resident at risk for choking, aspiration, and death. During a phone interview on 5/11/26 at 3:36 p.m., the dietician stated according to the national dysphagia diet textures foods should be fork mashable. The dietician stated she would further check the requirements. A follow up phone interview at 4:04 p.m., the dietician stated there were no measurement requirements for an NDD Level 3 diet. The dietician further stated vegetables for an NDD Level 3 diet should be soft, well cooked, and chopped if needed. Facility policy "Therapeutic Diet Orders" dated October 2023, identified the facility was to provide residents with foods in the appropriate form and/or appropriate nutritive content as prescribed by a physician and/or assessed by the interdisciplinary team to support the resident's treatment plan and goals. The policy defined a mechanically altered diet as one in which the texture or consistency of food is altered to facilitate oral intake and identified	20830		05/13/2026

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20830	Continued from page 8 examples including soft solids, pureed foods, ground meat, and thickened liquids. The policy further identified dietary and nursing staff were responsible for providing therapeutic diets in the appropriate form and/or appropriate nutritive content as prescribed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), dietary manager, speech language pathologist (SLP), or designee could review and/or revise facility policies and procedures related to dysphagia management and therapeutic food texture consistency. The facility could provide education and competency validation for nursing and dietary staff regarding implementation of prescribed dysphagia diets and appropriate food textures according to physician orders and facility guidelines. The facility could implement a monitoring system including meal observations and tray audits to ensure residents receive the correct food texture consistency as ordered. The DON, dietary manager, SLP, or designee could report findings, corrective actions, and ongoing monitoring results to the Quality Assurance Performance Improvement (QAPI) committee for a determined period of time until compliance is achieved and maintained. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		05/13/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Rehabilitation And Living Center	**1900 BALLINGTON BOULEVARD NW , ROCHESTER, Minnesota, 55901**

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F0000	INITIAL COMMENTS On 3/24/26, 3/25/26, 3/26/26, and 3/27/26 a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H56269020C (2807600) and H56269061C (2808514) with deficiencies issued at F686, F684, F657, and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		04/23/2026
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote	F0686	Plan of Correction F0686 SS=G Affected Residents: The care plans and kardex for R1 and R5 have been reviewed and updated. R1 and R5 have been seen by the wound Nurse and have had comprehensive wound assessments completed. R1 received a specialty air mattress to promote wound healing. R4 discharged from the facility on 4/3/2026.	05/01/2026

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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F0686 SS = G	Continued from page 1 healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to monitor, comprehensively assess, develop, and implement individualized interventions to prevent/mitigate the risk of pressure ulcers and/or deterioration for 3 of 4 residents (R1, R4, R5) reviewed for pressure ulcers. This caused actual harm to R1 who developed an avoidable unstageable pressure ulcer on her coccyx which needed surgical debridement and hospitalization. Findings include: Pressure Ulcer/Injury (PU/PI) is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear. “Eschar” is dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound. i Stage 2 Pressure Ulcer: Partial thickness skin loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss.	F0686	Continued from page 1 Potentially Affected Residents: All other residents have the potential to be affected. A skin sweep was completed of all residents in the building to ensure all skin concerns have been identified. Reviewed all residents with current pressure ulcers to ensure comprehensive assessment completed, monitoring is in place (if applicable), individualized interventions for prevention are in care plan, and provider notification occurred. Measures/Systemic Changes: Facility signed agreement with Advanced Comfort Health to transition to a new wound care provider. Facility signed agreement with Curitec to transition to their services. Implemented a room move checklist to ensure all items are moved with resident, care plan review after room move, and all other necessary room move functions are completed. Facility to send a list to wound care provider weekly indicating who should be seen for wound rounds. Facility RN to complete wound rounds with wound NP each week and document assessments in EMR. A new process was created in the event wound NP is unavailable, the primary provider will be notified to complete comprehensive wound assessments that week. Education provided to licensed nurses on provider notification including who to notify about changes to wound condition, comprehensive wound assessment, and wound formulary sheets. Education provided to licensed nurses on E-Interact	05/01/2026

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F0686 SS = G	Continued from page 2 Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable PU/PI. Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration: Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur. Moisture Associated Skin Damage: inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, sweat, wound drainage, saliva or mucus. R1's face sheet dated 3/27/26, identified diagnoses of primary progressive multiple sclerosis (MS), hereditary spastic paraplegia, obesity, pressure induced deep tissue damage to left heel. R1's nursing home nurse practitioner (NP) note dated 2/6/26, identified R2 had a stage 2 pressure ulcer on left buttocks that had resolved and a deep tissue injury to the left heel.	F0686	Continued from page 2 Change of Condition and E-Interact Transfer forms in PCC. Education provided to all staff on room move checklist. Monitoring: The DON or designee will perform weekly audits of skin assessments and care plan compliance for 5 residents for 5 months to ensure changes are permanent. Volunteers of America Corporate Support will monitor skin checks daily for 2 weeks, then as need until substantial compliance is achieved. Date of Alleged Compliance: 5.1.2026.	05/01/2026

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F0686 SS = G	Continued from page 3 R1's hospital discharge summary dated 2/24/26, identified R1 had been hospitalized for an insertion of a pain management pump. R1 had a preexisting pressure induced deep tissue damage to the left heel and a new gluteal cleft lesion for which the wound nurse had been consulted. R1's hospital after visit summary (AVS) dated 2/24/26, identified R1 had irritant contact dermatitis on her bilateral gluteal cleft and had treatment to cleanse area twice daily and apply barrier cream three times per day and as needed. R1's Braden Scale for Prediction of Pressure Ulcer Risk Evaluation dated 2/24/26, identified R1 was high risk for developing pressure ulcers due to being slightly limited to respond to verbal commands, cannot always communicate discomfort or need to be turned, being constantly moist, chairfast, very limited mobility due to making only slight changes in body or extremity position but unable to make frequent or significant changes independently, probably inadequate nutrition, and potential problem with friction and shear. R1's ADL focus care plan dated 10/31/25, identified R1 triggered in ADL's because she had preferences and other items of need. Goal to maintain current level of ADLs. Interventions as follows: -Assist of two for bed mobility. (dated 2/24/26) -Assist of two using full body mechanical lift for transfers. (dated 2/24/26) R1's physician orders identified an order dated 11/7/25 to frequent every 2 hours repositioning for wound care. R1's Skin focus care plan revised on 2/24/26, identified R1 had an actual pressure injury related to MS, increased need of activities of daily living (ADL) assistance with mobility, history of ulcer prior to admission and a deep tissue injury to left heel identified on 1/8/26. Goal to show no complications in skin integrity. Interventions as follows: -Inspect skin daily with cares. (dated 10/31/25) -Follow wound care orders. (Dated 11/11/25) -Weekly skin checks completed by nursing. (dated 12/15/25)	F0686		05/01/2026

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F0686 SS = G	Continued from page 4 -Pressure ulcer care to left heel as ordered. (dated 1/15/26) -Nutritional supplements per dietician order to support wound healing. (Dated 2/2/26) -Gel mattress applied 2/13/26. (dated 2/16/26) R1's Nursing Data Collection Admission/Readmission form dated 2/24/26, identified an unstageable pressure ulcer on left heel that was present on admission/readmission, with no measurements or characteristics of the wound. R1 also had contact dermatitis of the left and right gluteal fold, with no measurements or characteristics. Nursing Data Collection identified R1 could not reposition while lying in bed, did not ambulate, not able to reposition when sitting in chair or wheelchair, had a pressure reducing wheelchair cushion in place and had a pressure reducing mattress. R1's Significant Change Minimum Data Set (MDS) dated 2/26/26, identified R1 had intact cognition, no behaviors, no rejection of care, dependent for toileting hygiene, had lower extremity limitation of range of motion, used a wheelchair, substantial/maximum assistance to roll left and right in bed, dependent for transfers, did not ambulate, occasionally incontinent of urine, always continent of bowel, was at risk for pressure ulcers, had one or more unhealed pressure ulcers/injuries, had one unstageable pressure ulcer that was not present on admission, no arterial/venous ulcers, had moisture associated skin damage (MASD), had pressure reducing device for chair and bed, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care, had application of non-surgical dressing other than feet, application of ointments/medication other than feet, had application of dressings to feet. R1's Nursing Weekly Skin Check dated 2/27/26, identified R1 had an unstageable pressure ulcer to the left heel and contact dermatitis to the left and right gluteal fold. Weekly Skin Check did not identify measurements or other wound characteristics. Review of R1's Treatment Administration Record (TAR) from 2/1/26 through 2/28/26, included a physician order dated 11/7/25 to reposition R1 every 2 hours. Documentation noted one refusal marked on 2/12/26 at 2:00 a.m. Repositioning not signed off on 2/25/26 at 8:00 a.m.; 2/26/26 at	F0686		05/01/2026

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F0686 SS = G	Continued from page 5 10:45 p.m.; and 2/27/25 at 10:45 p.m. R1's Nursing Weekly Skin Check dated 3/3/26, identified R1 had a stage 2 pressure ulcer on her coccyx with measurements of 1.84 centimeters (cm) x 1.14 cm (no depth was documented even though the record identified the wound as stage 2 pressure ulcer.) Additional wound was unstageable pressure ulcer on left heel that measured 2.29 cm x 2.15 cm x 0.1 cm. (no other characteristics included). Contact dermatitis on left and right gluteal fold (no measurements or further description included). Comment of new coccyx pressure ulcer stage 2 and will be seen by wound nurse tomorrow. R1's record identified a Situation, Background, Assessment, Response (SBAR) dated 3/3/26 to inform physician of stage 2 pressure ulcer on coccyx. Nursing intervention to cleanse with normal saline, place Mepilex (name brand of foam) dressing to area daily (in accordance with facility standing orders) and as needed if soiled or dislodged. Also stated need recommendations for "restriction" 30 degrees so resident is not bedbound. SBAR also indicated that will talk with R1 about adding back air mattress. SBAR did not indicate measurements of wound, nor any other wound characteristics. During an interview on 3/25/26 at 9:32 a.m., environmental services director (ESD) stated his department moved R1 to a different room on 3/4/26, however, the gel mattress never got moved to her new bed. R1's Interdisciplinary Team (IDT) Team Initial Post Investigation Review dated 3/5/26 at 12:00 p.m., identified a new skin condition from 3/3/26 in which after the review of investigation the IDT's root cause of the incident was that R1 was staying in bed more often, per choice and is incontinent of bowel and bladder and is extensive assistance with bed mobility, unable to make micro-shifts. R1's care plan was reviewed and root cause identified. R1 was high risk for skin breakdown due to reasoning as the forementioned. Treatment interventions are put in place and carried out. R1's Wound Nurse Practitioner visit note dated 3/5/26, indicated reason for visit was wound follow up of left heel and a new coccyx wound. R1's heel continues to improve and is nearly closed, has a new open area on her bottom. R1 spends a lot of time in bed and encouraged to offload when in bed	F0686		05/01/2026

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F0686 SS = G	Continued from page 6 and wheelchair. The area is over a bony prominence and appears to be pressure related. Plan for coccyx wound was to cleanse and pat dry and cover with foam dressing, air mattress, pressure offloading, dietician consult for wound supplement recommendations. Review of R1's record from 3/3/26 through 3/16/26 identified the care plan had not been revised nor evident that an air mattress had been placed on R1's bed per wound nurse recommendations on 3/5/26. Review of R1's TAR from 3/1/26 through 3/20/26, identified a physician order dated 11/7/25 to reposition every 2 hours; did not identify R1 had any refusals of repositioning, however, repositioning had not been signed off as completed on 3/2/26 at 10:45 p.m. R1's Incontinence focus care plan revised on 11/3/25, identified R1 had altered elimination, needed treatment/monitoring/cares due to neurogenic bladder. Corresponding interventions dated 11/12/25 directed to empty Purewick (external urine collection system) and on 12/4/25 directed to Change Purewick cannister per order. R1's IDT Final Post Review Follow Up dated 3/10/26 (signed on 3/23/26), identified R1's new skin issue (did not identify what skin issue). Interventions were put in place after incident that team reviewing were wound care treatment ordered, repositioning and incontinent care increased. Effectiveness of the interventions put in place after the incident was documented as resident will refuse repositioning, though staff are still encouraging. R1's care plan did not reflect revision for any increases in repositioning since 11/7/25, nor did the incontinence care get increased, and not evident an individualized toileting program or schedule was developed and implemented. During an interview on 3/25/26 at 4:11 p.m. director of nursing (DON) explained the 3/10/26 IDT Final Post Review follow up indicated there would be an increase in incontinence care because she had heard R1 had been falling asleep on the bed pan, however, R1's care plan had not been revised to reflect she should not use the bedpan and should be using a commode instead. R1's Skin Issue Wound Assessment dated 3/12/26, identified R1 had a pressure ulcer/injury to middle coccyx that was stable: previously	F0686		05/01/2026

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F0686 SS = G	Continued from page 7 deteriorating; was in house acquired with onset date of 3/2/26. The assessment identified coccyx wound measurement of 1.79 cm x 4.03 cm which indicated worsening from the previous assessment on 3/3/26 measurement of 1.84 cm by 1.14 cm. The 3/12/26 assessment also described the wound as no tunneling, surrounding skin fragile, and no exudate. The assessment did not include any other characteristics. R1’s coccyx wound’s corresponding image taken 3/12/26, identified a large dark purple line on the left buttocks that extended to the right side of the buttocks. An unopened blister was noted on the left buttocks near the lateral part of the purple area. R1’s skin surrounding the wound was red in color. During an interview on 3/25/26 at 11:14 a.m., registered nurse case manager (RN-CM) stated she assessed R1’s coccyx wound on 3/3/26 and 3/12/26, however, during the 3/12/26 assessment R1's wound appeared stable to her. RN-CM confirmed R1's wound had increased in size and had a change in color which could indicate the wound was beginning to worsen. RN-CM stated the purple discoloration in the image did not appear as purple to her but more of a brown color and appeared more like a “scab”. RN-CM could not identify the type of wound associated with the purple discoloration she had documented on the 3/12/26 assessment. RN-CM indicated during the assessment she did not identify R1’s bed did not have the gel mattress according to the care plan. RN-CM reported she did not notify the physician of the increase in size of the wound or the change in color. During an interview on 3/25/26 at 4:11 p.m., DON stated RN-CM described R1’s coccyx wound to her on 3/12/26, and by the description she believed that R1’s coccyx wound had begun to change. DON explained she had instructed RN-CM to notify the physician; however, DON had not evaluated the wound herself to see what the changes were. DON further explained she had not followed up to ensure that the physician had been notified nor evaluated if R1’s pressure relieving interventions were effective. DON reviewed R1’s record and explained R1’s wound assessment that had been completed on 3/12/26 showed a change in R1’s wound from previous assessments showing deterioration. DON further explained R1’s wound had not been staged in the assessment and should have been identified as a deep tissue injury. DON stated the physician should have been notified and R1’s turning and repositioning schedule should	F0686		05/01/2026

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F0686 SS = G	Continued from page 8 have been reevaluated/increased, however, was not completed. R1's progress note dated 3/16/26 at 10:25 p.m., identified after R1's bath skin was assessed and noticed that coccyx area was dark purple/black in color with an odor. R1's record did not identify any other characteristics of the wound including measurements nor physician notification of newly identified discoloration. R1's progress note dated 3/17/26 at 4:41 p.m., was called to R1's bedside due to change sacral dressing due to soilage. Wound noted to be increased in size and drainage noted. Management updated. R1's progress note dated 3/17/26 at 5:00 p.m., identified R1 had a decline in her wound characteristics. R1 agreed to have staff come in and reposition her every 2 hours from her left to her right side (which was the original treatment order dated 11/7/25, identifying no increase in frequency). R1also stated she did not want to use the bed pan anymore and agreed to use the bedside commode for toileting needs. Email was sent to the nurse practitioner and wound nurse. Primary nurse practitioner will be in house tomorrow and will assess the wound. Air mattress was placed on R1's bed. During a follow up interview on 3/25/26 at 12:15 p.m., ESD explained a request had been made on 3/17/2 to place an air mattress on R1's bed, however, the maintenance staff mistakenly marked off that it was completed prior to being placed and R1's air mattress had not been placed on her bed until 3/18/26. According to an earlier interview on 3/25/26 at 9:32 a.m. ESD indicated that's when we found out the gel mattress had not moved to the new room with her on 3/4/26. R1's Skin Issue progress note dated 3/17/26, identified an evaluation of R1's middle coccyx wound. Issue type listed as a Kennedy Terminal Ulcer/End of Life stage 4 pressure ulcer that was in house acquired. The note identified the wound was deteriorating (from the previous assessment 3/12/26 noted 1.79 cm x 4.03 cm.) measurements on 3/17/26 documented as 4.11 cm x 7.93 cm x 1.0 cm; no tunneling; 10% slough; 90% eschar; moderate drainage that was seropurulent (thin, watery, cloudy wound discharge that is yellow to tan or pink in color indicating early signs of infection); surrounding tissue with erythema (redness); with moderate dressing saturation and	F0686		05/01/2026

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F0686 SS = G	Continued from page 9 pain described as sharp. R1's progress note dated 3/17/26, identified wound assessment dated 3/17/26, documented as a "Kennedy Terminal Ulcer/End of Life." Upon further clinical review, R1 was not actively dying and did not meet the criteria for a Kennedy Terminal Ulcer. R1's wound was more consistent with a pressure injury related to immobility, moisture exposure, and high-pressure injury risk. The wound will be managed according to the facility pressure injury protocol and wound care recommendations. Wound measurements, staging, and treatment orders remain accurate and ongoing monitoring will continue. R1's skin focus care plan was revised 3/17/26 to include the following interventions: -Turn and reposition every 2 hours and as needed, with continued staff encouragement and education if declines. -Provide prompt incontinence care and keep skin clean and dry to prevent moisture related skin breakdown. -Provide coccyx wound care as ordered. R1's elimination focus care plan revised on 3/17/26 to include the following interventions: -Use bedside commode and no longer use the bedpan. -Offer bedside commode every 2-3 hours and as needed. Able to state when need to use the bathroom and will also ask for assistance. During an interview on 3/25/26 at 4:11 p.m., DON stated on 3/17/26 R1's toileting care plan had been revised to not use the bedpan because she had heard from staff that R1 was falling asleep while sitting on the bedpan and this likely caused the development of a deep tissue injury on 3/12/26. DON explained that R1's care plan should have been revised at the time she heard about R1 falling asleep on the bedpan and not waited until R1's wound worsened on 3/17/26. R1's nurse practitioner note dated 3/18/26, identified nursing had notified NP about wound concerns with a worsening wound to coccyx.	F0686		05/01/2026

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F0686 SS = G	Continued from page 10 New orders to wound to cleanse with normal saline, pat dry, apply skin prep to surrounding intact skin, apply iodosorb (a sterile antimicrobial wound dressing used to remove slough/debris and killing bacteria) mixed with hydrogel to open wound, place foam dressing, change daily and as needed if soiled or dislodged. Nursing had implemented a scheduled offloading pressure every 2 hours and will no longer be using a bedpan. R1 now has an air mattress to relieve pressure. Review of R1's care plan identified the additional intervention of the air mattress on 3/18/26. During an interview on 3/25/26 at 4:11 p.m., DON stated she thought the NP was going to physically assess R1's buttock wound on 3/18/26, however, the NP only reviewed image from 3/17/26 and gave orders. R1's progress note dated 3/18/26 at 8:51p.m., identified R1's wound had an increase in foul smelling odor and pain increased since yesterday assessment. R1 continues to have blanchable redness to surrounding skin, wound bed with 90% necrotic (dead, non-viable tissue) tissue and 10% slough (yellow or white, soft that delays healing). Call placed to on-call physician to update on wound characteristics and will await call back. R1's Emergency Department (ED) Telemedicine (the use of delivery of healthcare services from a distance using a computer) note dated 3/18/26 at 9:38 p.m., identified R1 had been seen due to a sacral wound that has changed significantly in the past 48 hours with concern for infection as well as the skin around the wound seems red. Noted foul smell to the wound, normal vital signs, and not complaints related to the wound. Assessment identified that the wound was the size of the palm, wound itself is dark which was consistent with an eschar, surrounding redness that is blanchable. Area feels firm to nursing at bedside and wound itself is dry. The wound itself is expanding which is a concern given R1's ambulatory status, but it is difficult to ascertain whether the surrounding tissue is due to expansion of the wound and is not a stage 1 versus infection. Given the wound is dry and the patient remains clinically stable, elected not to transfer to the ED and will have wound assessed by the in-house provider tomorrow morning. ED note stated if the provider is not able to arrange for a provider to assess R1 at bedside in the morning, she will be transferred to the ED for evaluation at that time.	F0686		05/01/2026

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F0686 SS = G	Continued from page 11 R1's progress note dated 3/19/26 at 10:17 a.m., identified that a call placed to physician asking to have a provider to assess R1's wound. Note received from physician assistant regarding response from situation, background, assessment, and recommendation (SBAR) that was sent on 3/19/26. Electronic health record reviewed to include photo of wound taken 2 days prior (3/17/26), telehealth ED visit and phone call with an on-call provider. Response to SBAR sent was as followed: known difficulties assessing skin condition with telehealth visits, therefore, given lack of symptoms and photo from two days ago does show surrounding redness, not of concern at that time, will not send to the ED at this time. Orders to continue current wound treatment as ordered on 3/18/26. Continue scheduled offloading. Check vital signs every shift for 5 days. R1's progress note dated 3/19/26 at 10:22 a.m., identified writer talked with R1 regarding providers decision to wait until tomorrow and nursing to continue monitoring. Wound culture had been requested due to foul smelling odor, eschar to the wound with black/mixed purulent drainage, increase drainage and increase in pain from 3/17/26. During an interview on 3/25/26 at 4:00 p.m., DON stated on 3/19/26 she had sent an SBAR to see if a physician could assess R1's wound in person as per the Tele ED recommendations because the certified wound nurse practitioner had not been available to assess R1's buttocks wound. DON explained that the physician assistant sent back a response to continue to monitor in facility and not send R1 to the ED for evaluation. DON explained she felt R1's wound appeared infected and needed to be seen in the ED, but since the physician assistant declined to give an order to send to the ED, they continued to monitor R1 in the facility. DON confirmed that the facility had an order to send R1 to the ED if a physician could not see R1 in person on 3/19/26, however, did not send her to the ED for her possible infected wound and she should have just been sent. R1's nurse practitioner note dated 3/20/26, identified R1 had been seen for assessment of an unstageable (deep tissue injury) pressure wound that was contiguous (sharing a common border, touching, or being in proximity) site of back buttocks and hip. Nursing was concerned for	F0686		05/01/2026

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F0686 SS = G	Continued from page 12 infection and over the past 3 days the wound had increased in size and was malodorous (having an unpleasant, foul, or stinky smell). R1was afebrile (without fever) and declined pain. Dressing removed and had a large amount of purulent malodorous drainage; peri-wound was erythematous (redness) with area of eschar expanded in the past 3 days. Concern for infection and gave orders to send R1 to emergency department (ED) for further evaluation and management. R1's progress note dated 3/20/26, identified R1 left facility at 11:20 am with emergency management services. R1's ED note dated 3/20/26, identified R1 presented for concerns for an infected coccygeal wound. R1 had a large irregular wound over the coccyx with eschar and a little bit of slough. Redness to the left glute that is warm and firm. Yellowish drainage that was foul smelling on the dressing. R1 was afebrile and hemodynamically stable. R1 was admitted for consideration of wound debridement and antibiotics. Computed tomography (CT) did not identify a discrete abscess or suggestion of osteomyelitis. Impression was sacral decubitus ulcer with associated left gluteal soft tissue phlegmons (a severe, spreading, non-encapsulated bacterial inflammation of soft tissue) with no evidence of osteomyelitis. R1's hospital History and Physical Hospital note dated 3/20/26, identified R1 was admitted for concerns for an unstageable pressure ulcer. A couple of days ago, nursing staff had a ED telemedicine activated and recommended short term in-person follow up. Evaluation revealed the wound note to be foul smelling with a large necrotic area surrounded by erythema (redness). R1 will need debridement of this large wound. R1 was treated empirically with intravenous antibiotics. R1's hospital note dated 3/21/26, identified R1 had surgical debridement on 3/21/26. R1 had new and worsening anemia with studies consistent with anemia or chronic disease. R1's A1C was markedly elevated which although confounded her anemia may explain the fast worsening of her wound. R1's hospital general surgery consult note dated 3/21/26, identified R1 had been admitted for management of an unstageable pressure ulcer. R1's wound in the sacral area was malodorous and had necrotic eschar with surrounding induration and erythema. R1's wound will need to be surgically debrided and would require multiple return trips to the operating room, dressing changes versus wound	F0686		05/01/2026

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F0686 SS = G	Continued from page 13 VAC placement. The operative note report dated 3/21/26, identified R1 had a debridement and irrigation of ulcer to the ischium/sacrum. Findings included necrotic fat with pockets of foul-smelling purulence, R1 had an excisional debridement of sacral wound down to healthy bleeding tissue that measured 11.5 cm x 9.5 cm x 3.0 cm. Pale muscle fibers at the base of the wound were left. R1's infectious disease hospital note dated 3/24/26, identified R1 had been admitted due to a necrotic sacral wound that was debrided on 3/21/26 with culture that grew Proteus, Staphylococcus epidermidis, and Enterococcus. Plan to treat R1 for 2 weeks using broad spectrum antibiotics while in hospital and switching to oral antibiotics. During an interview on 3/25/26 at 2:55 p.m., nursing assistant (NA)-B stated she had not been aware R1 was supposed to be on a gel mattress and relies on looking at the resident's care plan to identify if they were on a special mattress. NA-B indicated she was unaware of R1's current care plan that directed no bedpan and to use commode at bedside. NA-B stated she had heard R1 had fallen asleep on a bedpan and that was the reason her bottom had gotten worse but was not aware when or who left R1 on a bedpan for an extended period of time. During an interview on 3/24/26 at 3:57 p.m., NA-D stated when she worked with R1 she would sometimes fall asleep on the bedpan and forget to ask for staff to take her off, however, NA-D stated staff should be aware if they placed a resident on a bedpan to ensure to take them off in a timely manner to prevent a sore from developing. NA-D had not heard R1 was not supposed to use the bedpan until after her sore had already worsened. During an interview on 3/24/26 at 3:44 p.m., NA-E stated he was not aware of which residents were at risk for skin breakdown, because his paper care guide did not identify those residents were on a repositioning program. NA-E stated he had not repositioned any resident since he came on shift at 6:00 a.m. NA-E explained he had not received any recent education on pressure ulcer prevention and if he had a resident with a new open area on a resident's skin he would make sure to clean the area, apply a barrier cream, and then tell the nurse next time he saw them. During an interview on 3/25/26 at 4:11 p.m., DON stated she had not been aware that R1's gel mattress had not been moved to her new bed on	F0686		05/01/2026

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F0686 SS = G	Continued from page 14 3/4/26 until she assessed R1's wound on 3/17/26 and identified R1's wound had deteriorated. DON identified R1 should have had an air mattress put in place on her readmission on 2/24/26 due to spending more time in bed than she had before. DON stated the IDT team had reviewed R1's coccyx pressure ulcer on 3/5/26 and 3/10/26, however, had not amended R1's pressure reduction intervention to mitigate the risk of her pressure ulcer from worsening. DON explained she had been informed prior to the 3/10/26 IDT meeting R1 had been left on a bedpan for an undetermined amount of time, however, had not made any changes to her not using the bedpan until R1's buttocks pressure ulcer worsened on 3/17/26. DON confirmed she had completed the wound assessment of R1's coccyx wound on 3/17/26 and initially identified her ulcer as a "Kennedy Ulcer/End of Life Ulcer and then changed her ulcer to a stage 4 pressure ulcer. DON stated R1's ulcer at the time of the assessment had been incorrectly identified as a stage 4 pressure ulcer when it should have been identified as an unstageable pressure ulcer. DON believe the root cause of R1's getting a pressure ulcer was due to being left on the bedpan for an extended period of time and not have a gel mattress on her bed since 3/4/26. During an interview on 3/26/26 at 4:07 p.m., physician assistant (PA) stated she had been informed via SBAR to see if she was available to assess R1's worsening buttocks wound in person on 3/19/26, however, there was not physician available to assess R1's wound in person, so she gave recommendation for monitoring in the facility until her wound could be assessed on 3/20/26. PA stated she was aware of R1's pressure ulcer and had been informed by the NP that the likely cause was due to R1 sitting on a bedpan for an undetermined time. PA stated her expectation for the facility was to put pressure relieving measures in place immediately to prevent a pressure ulcer and/or to avoid deterioration of an existing pressure ulcer. During a return phone call on 4/1/25 at 11:36 a.m., NP stated when he had assessed R1's wound on 3/20/26 it appeared to be infected and had a large amount of purulent drainage and had foul odor and proceeded to send R1 to the ED for further evaluation of her wound. NP stated she had been informed at an earlier time that R1 had been left on the bedpan for an unknown amount of time and this likely caused the unstageable pressure ulcer. NP stated R1's toileting plan should have been changed as soon as it was identified she had been	F0686		05/01/2026

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F0686 SS = G	Continued from page 15 sitting on the bedpan for a long time and that she had not been informed R1's gel mattress had not been in place on her bed since 3/4/26. NP explained that by R1 not having her gel mattress in place could have likely caused R1's buttocks wound to deteriorate, and her pressure ulcer could have been avoided if all of the interventions had been in place. During an interview on 3/26/26 at 2:12 p.m., medical director (MD) stated it is his expectation for the facility to ensure all residents who are at risk for pressure ulcers have interventions put in place immediately to mitigate the risk of developing a pressure ulcer. If the resident develops a pressure ulcer the treatment/interventions need to be continually evaluated to ensure the pressure ulcer does not deteriorate. R1 not having a gel air mattress, by not altering pressure reducing interventions could have caused deterioration in her pressure ulcer thus making the pressure ulcer avoidable. During an interview on 3/24/26 at 2:29 p.m., administrator stated during the facility investigation of R1's worsened pressure ulcer that occurred on 3/17/26, it had been discovered that on 3/4/26 when R1 was transferred to a different room her gel mattress had not been applied to R1's new bed following the room change. Administrator further explained that on 3/17/26 the facility implemented a room move checklist to ensure future resident room changes that occur will ensure all pressure relieving interventions were in place at the time of the move. Administrator further explained the facility also reviewed all residents that utilized a specialty pressure reducing mattress and added an order in the treatment record to ensure the mattress was in place and functioning properly, education was provided to all nursing staff on pressure ulcer care/prevention/interventions, change of condition, and notification of physician along with a knowledge quiz on each area trained on. Despite education provided to staff according to the administrator on 3/17/26, non-compliance with pressure ulcer assessments and implementation of the care plan was identified for R4 and R5. R4 R4's Diagnoses report dated 3/27/26, identified diagnoses of diabetes and chronic kidney disease.	F0686		05/01/2026

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F0686 SS = G	Continued from page 16 R4's admission MDS dated 3/7/26, identified R4 had intact cognition, no behaviors, no rejection of care, used a walker, used a wheelchair, needed partial or moderate assistance with taking off footwear, independent with rolling left and right in bed, partial of moderate assistance for transfers, needed supervision or touching assistance for ambulation, was at risk for developing pressure ulcers, had no unhealed pressure ulcers, no arterial or venous ulcers, had a pressure reducing device for chair and bed, did not receive any application of dressings or ointments to feet. R4's Nursing Data Collection: Admission/Readmission dated 3/3/26, identified R4 did not have any wound present. R4 had a pressure reducing mattress in place. R4's skin focus care plan initiated 3/3/26, did not identify a problem with skin. Goal of not to show complications in skin integrity. Intervention dated 3/3/26 as follows: -Inspect skin daily during care, nursing assistant to report any concerns to nurse. R4's Braden Scale for Predicating Pressure Ulcer Risk Evaluation dated 3/3/26, identified R4 was low risk for developing pressure ulcers. R4's Nursing Weekly Skin Check dated 3/7/26, indicated R4 had no skin issues. R4's progress note dated 3/10/26 at 5:40 a.m., identified R4 had a blister to left heel that measured 2.5 cm x 3.0 cm with no current treatment. New intervention of blue heel boots placed on R4. R4's record did not identify any other wound characteristics. R4's progress note dated 3/10/26 at 11:21 a.m., identified R4 had a new blister on his left heel that was identified on 3/9/26. Foam boots applied to support healing and reduce pressure. R1's record did not identify any documentation of left heel issue on 3/9/26. R4's progress note dated 3/10/26, identified SBAR sent to physician for blister on left heel. R4's physician order dated 3/10/26, included an order for left heel to cleanse with normal saline, apply foam dressing, change daily and as needed if	F0686		05/01/2026

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F0686 SS = G	Continued from page 17 soiled or dislodged and heel protectors while in bed every shift. R4's Wound Assessment dated 3/12/26 (completed two days after identification of blister), identified R4 had a stage 1 pressure ulcer on left heel that measured 3.37 cm x 3.42 cm, with continuous aching pain, redness noted around the surrounding skin. R4's progress note dated 3/12/26, identified a Braden Scale for Predicting Pressure Ulcers completed with no sensory impairment, rarely moist, walks occasionally, had no limitations, able to make major and frequent changes in position, adequate nutrition, and had a potential problem with friction/shear, and identified as a low risk for developing pressure ulcers. R4's Nurse Practitioner note dated 3/13/26, identified R4 had a deep tissue injury to left heel measuring 2.5 cm x 3.5 cm intact fluid filled blister with no evidence of infection and to continue plan of care. R4's Nursing Weekly Skin Check dated 3/14/26, identified R4 had an "other" wound on left heel. The weekly skin check did not identify any measurements or description of the wound. R4's skin focus care plan problem revised on 3/16/26 (6 days after the identification of the blister) that R4 at risk for skin injury related to pressure due to decreased mobility. Intervention added 3/16/26 of pressure reducing device for chair and bed. R4's Wound Assessment dated 3/21/26, identified a Stage 2 pressure ulcer on his left heel. Measurements of 2.56 cm x 2.4 cm, intermittent sharp pain, with intact unbroken surrounding skin. The assessment did not include any other wound characteristics. R4's skin focus care plan revised on 3/21/26 to offer offloading every 2-3 hours and as needed. R4's skin focus care plan revised again 3/24/26 to turn and reposition every 2 hours and as needed. During an observation and interview on 3/25/26 at 10:58 a.m., R4 was lying on his bed with shoes on and his heels resting on his bed. R4 did not have heel protectors on while in bed. NA-C then entered R4's room and took his meal order, however, did not ask R4 if she could put R4's heel protectors on his feet. NA-C stated R4 had a pressure ulcer on his left heel and was supposed to have his heel protectors on when in bed but had not noticed that	F0686		05/01/2026

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F0686 SS = G	Continued from page 18 they were not on when he was lying in his bed. NA-C then went back into R4's room and applied both heel protectors on his feet. During an interview on 3/26/26 at 10:18 a.m., NA-A stated R4 received an air mattress today due to a pressure ulcer on his left heel. R4 was supposed to be wearing blue boots on his bilateral heels when in bed, however, he would self-transfer at times and lay in his bed without his blue boots. NA-A stated R4 should have had the air mattress as soon as the heel pressure ulcer was identified. NA-A could not articulate on how to identify if a resident was identified as high risk for pressure ulcers and relied on being informed at report from the nurse if they were supposed to be on a turning and repositioning schedule. During an observation and interview on 3/27/26 at 9:11a.m., R4 was seated in his recliner with shoes on. Certified Wound Nurse Practitioner (CNP-WOC) removed R4 left shoe and described R4's wound as a reabsorbed blister on the back of R4's left heel. CNP-WOC stated that the wound was from pressure from the bed or from shoe. R4 stated a while ago he fell asleep "hard" in bed one night and woke up with terrible pain in his left heel and since then he put on these special "boots" in bed. R4, stated he has numbness in his feet at times and that may be why he did not feel it hurting. CNP-WOC recommended R4 not wear shoes and use gripper socks until the wound was completely healed. R4's Wound Nurse Practitioner note dated 3/27/26, identified R4 had been seen for a blister on his left heel. Recommendations to wear gripper socks when up and blue heel boots on when in bed. Continue order to cleanse with normal saline, apply skin prep to entire wound, allow to dry, apply foam dressing, change daily and as needed if soiled. R5 R5's Diagnosis report dated 3/27/26, identified diagnoses of fracture of right femur, heart failure, cancer of the prostate, diabetes, and end stage renal disease. R5's Braden Scale -for Predicting Pressure Ulcer Risk Evaluation dated 1/20/26 identified R5 was low risk for developing pressure ulcers. R5's ADL focus care plan dated 1/20/26, identified R5 triggered in ADLs because had preferences and other items of	F0686		05/01/2026

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F0686 SS = G	Continued from page 19 need. Goal to gain endurance with transfers and ambulation. Interventions as follows: -Extensive assistance for bed mobility. R5's Skin focus care plan dated 1/20/26 (revised on 1/30/26), identified R5 was at risk for pressure injury. Goal to remain free from pressure injuries or skin breakdown. Interventions as follows: -Inspect skin daily with cares and nursing assistant to report any concerns to the nurse. (dated 1/20/26). -Pressure reducing cushion for wheelchair. (dated 1/20/26) R5's hospital discharge summary dated 3/10/26, identified R5 had been hospitalized 2/27/26 through 3/10/26 for a repair of fracture of the right hip. R5's Braden Scale-for Predicting Pressure Ulcer Risk Evaluation dated 3/10/26, identified R5 was moderate risk for pressure ulcers due to no impairment with sensory, very moist skin, being chairfast, being very limited with mobility, adequate nutrition, and problem with friction/shear. R5's skin focus care plan interventions revised on 3/10/26 to turn and reposition every 2-3 hours while sleeping. R5's Nursing Weekly Skin Check dated 3/10/26, identified R5 had no skin issues except for edema in bilateral lower extremities. R5's physician orders identified the following: -Elevate heels when in bed. (dated 3/10/26) -Reposition every 2 hours. (dated 3/22/26) R5's significant Change MDS dated 3/16/26, identified R5 had intact cognition, no behaviors, no rejection of care, used a wheelchair, dependent for toileting hygiene, substantial/maximum assistance for roll left and right in bed, dependent for transfers, at risk for developing pressure ulcers, had no unhealed pressure ulcers/injuries, no venous/arterial ulcers, had pressure reducing device in chair, no pressure reducing device in bed, and received dialysis. R5's Nursing Weekly Skin Check dated 3/19/26, identified a pressure ulcer on coccyx measuring 2.0 cm x 1.0 cm, no depth nor staging, with skin breakdown on the coccyx, area cleaned	F0686		05/01/2026

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F0686 SS = G	Continued from page 20 and applied zinc and covered with foam dressing. R5's Skin Issue Wound Assessment dated 3/19/26, identified a stage 2 pressure ulcer on coccyx that measured 1.2 cm x 1.67 cm, with no depth identified, with 100% granulation, no drainage, with erythema/dry skin noted in surrounding tissue. R5's physician orders identified an order dated 3/22/26 for Mepilex dressing to stage 2 pressure ulcer on buttocks to change every 72 hours and as needed until healed. R5's physician orders dated 3/22/26, identified an order for an air mattress to check every shift for proper placement and functioning. During an interview on 3/27/26 at 9:42 a.m., registered nurse (RN)-A stated R5 had been complaining of pain in his left heel since yesterday, however, RN-A had not completed a skin assessment on R5's heel to check for any pressure concerns. During an observation and interview on 3/27/26 at 9:03 a.m., R5 was seated in his chair, DON and NA-F then used a stand aid to place R5 in bed. R5 informed DON that his left heel hurt "really bad". R5 was then placed in bed and continued to state his left heel hurt. DON removed R5's brief and an open area was noted on his left buttocks with no dressing over the wound that was approximately 2.0 cm x 2.0 cm in size, with the top layer of skin off the wound, red center, and maceration noted around the edges of the wound. DON described the wound as a stage 2 pressure ulcer. CNP-WOC identified wound as a stage 2 pressure ulcer and needed to be covered at all times. R5 complained of severe pain in his left heel, CNP-WOC assessed R5's left heel and stated heel was "boggy" and had a deep tissue injury approximately 0.5 cm x 0.5 cm. RN-B entered R5's room and stated she had been informed by the night shift nurse that R5's coccyx dressing change had been completed, however, RN-B was not aware R5 did not have a dressing on his buttocks wound. RN-B explained that she had been informed that R5 had refused to wear his blue boots last night but was unsure of the rationale for not wearing the boots. During an interview on 3/27/26 at 10:11 a.m., RN-C stated she had worked the night shift on 3/27/26 and during that time R5 had refused to wear his heel protectors during the night shift and RN-C explained she had provided R5 education of the risks of not wearing the heel protectors, however,	F0686		05/01/2026

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F0686 SS = G	Continued from page 21 R5 continued to refuse. RN-C stated she had applied an as needed coccyx dressing to R5 at the beginning of her shift, however, had not documented in R5's record when she had applied a new dressing. RN-C stated R5 had not complained of pain in his left heel during the night shift, however, RN-C had not assessed R5's heels nor asked the reason why R5 did not want to wear the heel protectors. R5's Wound Nurse Practitioner note dated 3/27/26, identified R5 was seen for a stage 2 pressure ulcer on coccyx. R5 complained of pain in left heel and noted a deep tissue injury to the area. New orders to buttocks ulcer to cleanse with wound cleanser, pat dry, apply foam dressing every 72 hours and change as needed, apply barrier cream to wound; left heel deep tissue injury orders to cleanse with normal saline, pat dry, cover with betadine, complete daily, apply blue boots on when in bed. During a return phone call on 4/1/26 at 11:36 a.m., NP stated when R5 was readmitted from the hospital on 3/10/26 for a hip fracture, his mobility status changed and should have had an air mattress put in place on readmission to mitigate the risk of developing a pressure ulcer and that R5's stage 2 pressure ulcer he developed was avoidable. During an interview on 3/25/26 at 3:42 p.m., licensed practical nurse (LPN)-B was not able to articulate how to complete and assessment of a new skin issue of redness (such as blanchable versus non-blanchable redness) or what type of interventions she would put in place for an identified new skin concern. LPN-B explained if staff had brought a concern of a purple area on a heel this would indicate that the resident may have fallen in which had caused a "bruise" and would not be related to pressure. LPN-C could not articulate what a deep tissue injury was or how they develop on bony prominences. During an interview on 3/26/26 at 2:01 p.m., DON stated she had not received any training on being able to complete a comprehensive wound assessments and sometime she did not feel comfortable identifying specific wound staging and relies on the certified wound nurse to assist with making wound type of determinations. Review of the facility's Pressure Injury Prevention Policy dated 1/21/26, identified the facility will maintain a systematic, interdisciplinary approach to pressure injury prevention and management. All residents will be assessed for risk	F0686		05/01/2026

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F0686 SS = G	Continued from page 22 upon admission and as clinically indicated, and those identified as at risk will receive individualized, evidence-based interventions to prevent the development of pressure injuries. The facility will monitor the effectiveness of these interventions, promptly address changes in condition, and revise care plans as necessary to ensure optimal outcomes and compliance with professional standards of practice. Assessment of Pressure Injury Risk: -Licensed nurses will conduct a pressure injury risk assessment and full body skin examination on all residents. -If a new wound is identified, documentation, notification, and follow-up will be conducted in alignment with established procedures. -Risk assessment will also be conducted after a significant change in condition that may affect pressure injury risk (e.g., decline in mobility, change in nutritional status, new incontinence, prolonged acute illness). -A standardized pressure injury risk assessment will be conducted, using a validated risk assessment tool or scale. The Braden Scale for Predicting Pressure Injury Risk (Braden Scale) has been designated as the standardized tool. -The Braden Scale will be used in conjunction with other risk factors not captured by the risk assessment tools, including, but not limited to: Ongoing Evaluation of Resident Skin Condition: -Licensed nurses will conduct a full body skin evaluation on all residents on at least a weekly basis. -Nursing assistants will observe skin integrity during routine care activities such as bathing, toileting, repositioning, and dressing changes. Any redness, bruising, discoloration, or other skin concerns will be reported to the licensed nurse immediately and documented in accordance with established procedures.	F0686		05/01/2026

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F0686 SS = G	Continued from page 23 Interventions for Prevention of Pressure Injuries: -After completing a thorough evaluation, the interdisciplinary team will develop a relevant care plan that includes measurable goals for the prevention of pressure injuries with appropriate evidence-based interventions for all residents assessed as at-risk for developing pressure injuries. -Interventions will be based on specific factors identified in the risk assessment and the full body skin evaluation (e.g., moisture management, impaired mobility, nutritional deficit). -Basic or routine care interventions may include, but are not limited to: -Redistribution of pressure (e.g., repositioning, protecting and/or offloading heels, etc.); minimizing exposure to moisture and keeping the skin clean; providing appropriate pressure-redistributing support surfaces; providing non-irritating surfaces; and maintaining or improving nutrition and hydration status. -Residents identified as at-risk for pressure injury development will be referred to the dietician for evaluation of nutritional and hydration status. Nutritional interventions (e.g., supplements, fortified meals, hydration plans) will be incorporated into the resident's care plan as appropriate. -Interventions will be implemented in accordance with provider orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them. -In the absence of prevention orders, the licensed nurse will utilize professional judgment in accordance with pressure injury prevention guidelines to provide care and will notify the provider to obtain orders. -The selection of prevention devices and support surfaces (e.g., heel floatation devices, cushions, mattresses) will be based on individual risk factors, mobility, weight, and skin	F0686		05/01/2026

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F0686 SS = G	Continued from page 24 condition. Prevention devices and support surfaces will be utilized in accordance with the manufacturer's recommendations and evaluated regularly for effectiveness and condition. -The goals and preferences of the residents and/or their representatives will be included in the care plan. Preventative interventions and risk factors will be communicated to all staff involved in the residents' care, including nursing assistants, therapy staff, and dietary services to ensure coordinated implementation of the care plan. -Compliance with interventions will be documented in the medical record in accordance with established procedures. Ongoing Monitoring: -The effectiveness of interventions will be monitored through ongoing assessment of the resident. -A Focused Incident Review will be performed on each pressure injury that develops in the facility. Findings will be reported in the Quality Assurance and Performance Improvement (QAPI) meetings. -The effectiveness of current preventative modalities and processes will be discussed in accordance with the QAPI Committee schedule, and as needed when actual or potential problems are identified. -Pressure injury incidence and prevalence data will be trended and reviewed routinely as part of the facility's QAPI program to identify systemic opportunities for improvement. Modification of Interventions: -Any changes to the facility's pressure injury prevention and management processes will be communicated to relevant staff in a timely manner. -Resident care plan interventions will be modified as needed. Considerations for needed modifications include, but are not limited to: Changes in the resident's degree of risk for developing a pressure injury; New onset or recurrent pressure injury development; Lack of	F0686		05/01/2026

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F0686 SS = G	Continued from page 25 progression toward healing; Resident non-compliance, and/or changes in the resident's goals and preferences in accordance with their rights (e.g., end-of-life care); -Resident or representative decisions to decline or modify interventions will be respected and documented. Staff will educate the residents and/or representative regarding potential risks and alternatives when care is declined.	F0686		05/01/2026
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 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 observation, interview, and document review the facility failed to timely revise the care plan to include an individualized	F0657	Care Plan Timing & Revision F0657 SS=D Affected Residents(s): R 1's care plan was immediately reviewed and revised on 3.17.26 to include the following interventions: a personalized toileting and incontinence plan including discontinuance of bedpan and use of bedside commode, turning and repositioning schedule, specialized air mattress suited for individualized pressure injury. The Interdisciplinary Team (IDT) reviewed and updated the care plans for R1 and it remains current. DON reviewed care plan with R1 and family. Potentially Affected Resident(s): All other residents have the potential to be affected. DON to audit all other residents to ensure that all residents have individualized toileting and incontinence plan. Any residents noted to not have an individualized toileting and incontinence plan were immediately corrected to reflect this change. Measures/Systemic Change(s): Updated Clinical Stand-up form to include daily review of change of condition to capture change of condition and assign accountability to our nursing team for revisions to care plan.	05/01/2026

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F0657 SS = D	Continued from page 26 toileting/incontinence plan for 1 of 3 residents (R1) who were reviewed for impaired skin integrity that had impaired skin integrity. Findings include: R1's face sheet dated 3/27/26, identified diagnoses of primary progressive multiple sclerosis, hereditary spastic paraplegia, obesity, pressure induced deep tissue damage to left heel. R1's Significant Change Minimum Data Set (MDS) dated 2/26/26, identified R1 had intact cognition, no behaviors, no rejection of care, dependent for toileting hygiene, had lower extremity limitation of range of motion, used a wheelchair, substantial/maximum assistance to roll left and right in bed, dependent for transfers, did not ambulate, occasionally incontinent of urine, always continent of bowel, was at risk for pressure ulcers, had one or more unhealed pressure ulcers/injuries, had one unstageable pressure ulcer that was not present on admission, no arterial/venous ulcers, had moisture associated skin damage (MASD), had pressure reducing device for chair and bed, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care, had application of non-surgical dressing other than feet, application of ointments/medication other than feet, had application of dressings to feet. R1's Skin focus care plan revised on 2/24/26, identified R1 had an actual pressure injury related to MS, increased need of activities of daily living (ADL) assistance with mobility, history of ulcer prior to admission and a deep tissue injury to left heel identified on 1/8/26. Goal to show no complications in skin integrity. Interventions as follows: -Inspect skin daily with cares. (dated 10/31/25) -Follow wound care orders. (Dated 11/11/25) -Weekly skin checks completed by nursing. (dated 12/15/25) -Pressure ulcer care to left heel as ordered. (dated 1/15/26) -Nutritional supplements per dietician order to support wound healing. (Dated 2/2/26) -Gel mattress applied 2/13/26. (dated 2/16/26). R1's care plan did not include an individualized toileting plan.	F0657	Continued from page 26 All Licensed Nurses were re-educated on change of condition and change of condition awareness which included the requirement to update care plans following any significant change in status or new diagnosis. The IDT Team was educated on Comprehensive Care Plans, new stand-up process which includes identifying daily change of condition and updating care plans for impaired skin integrity. Quality Assurance & Monitoring Audits: The DON will audit timely care plan revisions which will include 4 care plan audits weekly for 4 weeks, then monthly for 3 months, or until substantial compliance is achieved. Care plans audits will focus on residents with recent assessments, or a change of condition. Reporting: Audit results will be presented at the monthly Quality Assurance & Performance Improvement (QAPI) meeting. Date of Alleged Compliance: 5.1.2026	05/01/2026

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F0657 SS = D	Continued from page 27 R1's Nursing Weekly Skin Check dated 3/3/26, identified R1 had a new stage 2 pressure ulcer on her coccyx with measurements of 1.84 centimeters (cm) x 1.14 cm and contact dermatitis on left and right gluteal fold. R1's IDT Final Post Review Follow Up dated 3/10/26 however was signed on 3/23/26, identified R1's new skin issue (did not identify what skin issue). Interventions were put in place after incident that team reviewing were wound care treatment ordered, repositioning and incontinent care increased. Effectiveness of the interventions put in place after the incident is that resident will refuse repositioning, though staff are still encouraging. R1's care plan did not reflect a revision to include any repositioning schedule nor incontinence care increased until 3/17/26 (seven days after the IDT review). Review of R1's care plan from 3/3/26 through 3/16/26 did not identify revisions pertaining to increased incontinence care. R1's progress note dated 3/17/26 at 5:00 p.m., identified R1 had a decline in her wound characteristics. R1 agreed to have staff come in and reposition her every 2 hours from her left to her right side. R1also stated she did not want to use the bed pan anymore and agreed to use the bedside commode for toileting needs. Email was sent to the nurse practitioner and wound nurse. Primary nurse practitioner will be in house tomorrow and will assess the wound. Air mattress was placed on R1's bed. R1's Skin Issue progress note dated 3/17/26, identified an evaluation of R1's middle coccyx wound. Issue type listed as a Kennedy Terminal Ulcer/End of Life. Progress listed as deteriorating; wound characteristics listed as deteriorated; Pressure ulcer staging as a Stage 4 pressure ulcer; wound in house acquired; increase in exudate (drainage); increase in size and smell; pain described as sharp; measurements recorded as 4.11 cm x 7.93 cm x 1.0 cm; no tunneling; 10% slough; 90% eschar; moderate drainage that was seropurulent (thin, watery, cloudy wound discharge that is yellow to tan or pink in color indicating early signs of infection); surrounding tissue with erythema (redness); with moderate dressing saturation. R1's skin focus care plan was revised on 3/17/26 to include the following:	F0657		05/01/2026

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F0657 SS = D	Continued from page 28 -Provide prompt incontinence care and keep skin clean and dry to prevent moisture related skin breakdown. R1's elimination focus care plan revised on 3/17/26, identified R1 had incontinence due to neurogenic bladder. Goal to cooperate in establishing a routine for urine elimination. Interventions as follows: -Use bedside commode and no longer use the bedpan. -Offer bedside commode every 2-3 hours and as needed. Able to state when need to use the bathroom and will also ask for assistance. During an interview on 3/24/26 at 3:57 p.m., nursing assistant (NA)-D stated when she worked with R1 she would sometimes fall asleep on the bedpan and forget to ask for staff to take her off, however, NA-D stated staff should be aware if they placed a resident on a bedpan to ensure to take them off in a timely manner to prevent a sore from developing. NA-D had not heard R1 was not supposed to use the bedpan until after her sore had already worsened. During an interview on 3/25/26 at 4:11 p.m., DON stated R1care plan had not been revised to include a turning and repositioning schedule, nor did her toileting care plan revised to not have R1 use the bedpan until 3/17/26. DON explained R1's care plan should have been revised as soon as she heard that R1 was falling asleep while sitting on the bedpan and not waited until 3/17/26 until after R1's pressure ulcer had worsened. Review of the facility's Comprehensive Care Plan Policy dated 4/11/25. Identified The purpose of this policy is to ensure that all residents receive individualized, person-centered care through the timely development, implementation, and ongoing review of comprehensive care plans. This policy ensures alignment with federal regulations and professional standards by outlining processes that assess resident needs and preferences, coordinating interdisciplinary team input, and promoting culturally competent and trauma-informed care. Development of the Care Plan. The comprehensive care plan must be: (a) Developed both: Within seven (7) days after completion of the comprehensive assessment, and Within 21 days after the resident's admission. (b) Prepared by an IDT that includes but is not	F0657		05/01/2026

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F0657 SS = D	Continued from page 29 limited to: The attending physician or, if unavailable, the designated non-physician practitioner (NPP) who is involved in the resident's care, to the extent permitted by state law. A registered nurse with responsibility for the resident.	F0657		05/01/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess an area of moisture associated skin damage and failed to notify the physician for 1 of 1 resident (R3) reviewed for non-pressure skin issues. Findings include: R3's face sheet dated 3/27/26, identified diagnoses of diabetes, Crohn's disease, and kidney transplant. R3's quarterly Minimum Data Set (MDS) dated 1/14/26, identified R3 had intact cognition, no behaviors, no rejection of care, needed partial/moderate assistance for transfers, was occasionally incontinent of bowel, has no pressure ulcers, had no venous or arterial ulcers, had no moisture associated skin damage, had an application of non-surgical dressing other than feet, application of ointment other than feet and receives dialysis. R3's Wound Assessment dated 2/26/26, identified R3 had a resolved moisture associated skin damage (MASD) to his right gluteus. R3's progress note dated 3/9/26, identified sacral wound cleansed and creams applied to sacrum as well. Sores are still open and present and R3 experienced pain with application of creams. R3's	F0684	Plan of Correction F684 SS=D Affected Resident(s): R3 orders were reviewed and verified as current, and the care plan has been updated to reflect current skin integrity needs and individualized interventions. R3 was assessed by wound nurse, the area of moisture associated skin damage was comprehensively assessed, measured, and documented in the medical record. Treatment orders have been implemented. Potential Affected Resident(s): All residents with non-pressure skin issues have the potential to be affected. All residents with non-pressure skin issues have been reviewed to ensure they had timely identification, comprehensive assessment, provider notification, and implementation of treatment. Care plans have been reviewed and updated to ensure they include comprehensive, person-centered interventions for non-pressure skin issues. Any identified concerns were immediately corrected. Measures/Systemic Changes: Clinical team to review all skin issues (pressure and non-pressure) daily at morning meeting to ensure timely assessment, provider notification, and implementation of treatment. Daily stand-up tool has been updated to include required skin review elements to ensure accountability and follow-up.	05/01/2026

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F0684 SS = D	Continued from page 30 record did not identify measurements of the wounds or any other wound characteristics, nor evident of physician notification. R3's Wound Assessment dated 3/12/26, identified R3 had an open lesion to the right gluteus that measured 0.3 centimeters (cm) x 0.21 cm. R3's wound assessment did not identify the type of wound nor other wound characteristics. R3's record did not identify physician had been notified or any treatment for open lesion. R3's Wound Assessment dated 3/19/26, identified R3 had an open lesion to the right gluteus that measured 0.6 cm x 0.74 cm. No other characteristics were documented. R1's progress note dated 3/20/26, identified nurse practitioner in facility to assess R3's right gluteal fold wound. NP is going to send new orders for wound care via fax. Instructed to cleanse, apply skin prep to surrounding tissue, apply Medihoney (an ointment that supports the removal of necrotic tissue and aids in wound healing) to wound bed and cover with foam dressing. R3's nurse practitioner note dated 3/20/26, identified R3 had a stage 3 pressure ulcer on left buttocks that measured 1.0 cm x 0.3 cm x less than 0.2 cm with 100% slough (yellow-tan necrotic tissue) in wound bed. Plan to cleanse daily with wound cleanser, pat dry, apply MediHoney to open wound, apply skin prep to peri wound, cover with 2 x 2 protective foam bordered dressing. Turn and reposition frequently and have dietician evaluate for nutrition support and wound healing. R3's physician orders identified the following order: -Cleanse buttocks and pat dry, apply house barrier cream twice daily and as needed for incontinence cares. (3/5/26 through 3/20/26) -Left buttocks: Cleanse with wound cleanser, apply Medihoney to open wound, apply skin prep to peri wound, cover with 2 x 2 protective foam dressing, change daily and as needed at bedtime. (dated 3/20/26) R1's record did not identify a treatment to the right gluteus wound. R3's progress note dated 3/24/26, identified a nutrition/dietary had a review of R3 due to new wound on gluteus that per registered nurse (RN) was considered a stage 2.	F0684	Continued from page 30 The policies "Resident Skin Evaluation", "Wound Treatment Management", and "Change of Condition" have been reviewed and remain current. Licensed Nurses will receive education regarding comprehensive skin assessments and E-INTERACT for proper and timely physician notification and identification of skin issues as a change in condition Monitoring: The DON or designee will audit all residents documented to have non-pressure skin issues using the non-pressure skin audit tool, ensure all new skin issues are identified timely, provider notification is completed via E-INTERACT, treatment orders are implemented, and comprehensive skin assessments have been completed. DON or designee to complete audit weekly for 4 weeks, then monthly for 3 months, or until substantial compliance has been achieved. Results will be reported to QAPI. DON or designee is responsible for compliance. Date of Alleged Compliance: 5.1.2026	05/01/2026

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F0684 SS = D	Continued from page 31 R3's progress note dated 3/24/26 at 1:00 p.m., identified an email sent to the nurse practitioner (NP) wanting to follow up on the staging of a previously moisture associated skin damage to R3's right gluteal area that was staged as a stage 3 pressure ulcer. Will wait for a response from NP regarding wound classification. During an interview on 3/26/26 at 1:45 p.m., director of nursing (DON) stated she had sent an image of R3's right gluteal wound to the nurse practitioner to evaluate prior to doing rounds on 3/20/26. DON explained R3's wound had not had a notification or gotten treatment until 3/20/26 and the physician should have been notified as soon as the wound was identified. DON was unaware the NP had labeled R3's wound as his left buttocks when it was his right gluteal area nor that it was classified as a stage 3 pressure ulcer. DON believed the wound may be moisture associated skin damage and was reaching out to a different provider to assist with the determination of the wound. During an interview on 3/26/26 at 2:12 p.m., medical director (MD) stated he had received a call from the facility to review an image of R3's right gluteal wound to assist with classification of the wound. MD stated he will be doing a telehealth video visit today (3/26/26) to assess R3's wound on his right gluteal area to see if he would be able to classify what type of wound it was. During an interview on 3/26/26 at 4:30 p.m., R3 stated he has this recurring area on his right buttocks that is painful. R3 stated he leaked stool ever since he had surgery a long time ago and staff put a special pad near his rectum to try and catch the stool. R3 got a special cushion for his wheelchair seat but a "donut" cushion for his chair was on order to help his bottom not hurt so bad. Just waiting for it to be delivered. During an observation and interview on 3/26/26 at 4:39 p.m., DON performed a telehealth visit with the medical director (MD) to assess R3's right gluteal wound. DON removed R3's brief where a foam dressing was on R3's right gluteus. DON removed the dressing where an approximately 0.5 cm x 0.5 cm open wound was present over what appeared to be a scar- pink skin was noted at the base of the wound, with maceration (occurs when the skin is exposed to moisture for too long) surrounding the wound. R3 stated he had an anal fistula (a tunnel that develops between the inside of the anus and	F0684		05/01/2026

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F0684 SS = D	Continued from page 32 the outside of the skin) repair over 40 years ago and had leaked stool ever since and believed it was in that same area of the wound. MD then assessed R3's wound and explained that the wound was not pressure related, and he would classify the wound as MASD due to the continued leaking stool and wanted to continue the current treatment and have the certified wound nurse practitioner evaluate the wound the next day to give further recommendations. During an interview on 3/26/26 at 5:15 p.m., registered nurse (RN)-D stated R3's wound was never on his left buttocks, however, the wound orders were for the left buttocks, but she just thought it was a mistake and had been applying the treatment to the right gluteal open area since there was no open area on the R3's left buttocks. During an interview on 3/26/26 at 2:01 p.m., director of nursing (DON) stated R3's right gluteus wound was identified as an open lesion, due to not "feeling comfortable" in being able to assess the type of wound R3 had on his buttocks. DON stated when the NP assessed the wound on 3/20/26 she identified it on the left buttocks, which was incorrect due to the wound his right gluteus that was assessed and as a stage 3 pressure ulcer and gave orders. DON initially thought the wound was a stage 2 pressure ulcer, but after review of R3's chart identified R3 had a history of MASD in the same areas in February. DON stated she relied on the certified wound nurse to assist with staging or to identify the type of wound, however, had not reached out to get clarification on R3's wound type. During an observation and interview on 3/27/26 at 7:31a.m., certified nurse practitioner wound nurse (CNP-WOC) assessed R3's right gluteal wound and classified the wound as MASD and changed the treatment order to the following: wash with normal saline, pack wound with collagen (wound dressing that promotes healing by stimulating new tissue growth), cover with foam, change daily and as needed soiling, may use barrier cream to surrounding peri wound for redness or irritation. Review of the facility's Wound Treatment Policy dated 1/21/26, identified Residents with wounds will receive necessary treatment and services, in accordance with provider orders and professional standards of practice, to promote healing, prevent infection, and prevent the development of new wounds unless clinically unavoidable. Wound	F0684		05/01/2026

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F0684 SS = D	Continued from page 33 treatment will be delivered using evidence-based practices, individualized to each resident's assessed needs, and documented, monitored, and reviewed to ensure effectiveness and regulatory compliance. I. General Requirements: Based on the comprehensive assessment of a resident, the facility will ensure that residents with pressure injuries and other types of wounds receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent the development of new wounds unless clinically unavoidable. Wound treatment and monitoring will be: Individualized based on the wound's etiology, contributing factors, and the residents. overall condition, goals, and preferences. In accordance with the residents' comprehensive care plan; and Consistent with professional standards of practice. II. Comprehensive Wound Assessment: A comprehensive assessment will be completed for each wound to determine etiology and contributing factors. This assessment will include: Underlying causes of the wound (e.g., pressure, shear, friction, vascular insufficiency, moisture, trauma, or other etiology); Contributing conditions or risk factors (e.g., nutrition, hydration, perfusion, mobility, incontinence, comorbidities, medications); and Consistent measurement of wound characteristics, including location, size, depth,	F0684		05/01/2026

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F0684 SS = D	Continued from page 34 tunneling, undermining, exudate, tissue type, and condition of the peri-wound skin. III. Treatment Orders: Wound treatments will be provided in accordance with provider orders, including: The cleansing method, Type of dressing, and Frequency of dressing changes. In the absence of treatment orders, the licensed nurse will notify the provider to obtain. orders. This may be the designated treatment nurse or the assigned licensed nurse in the absence of the treatment nurse. Treatment orders will be guided by current evidence-based wound care practices and interdisciplinary input when needed (e.g., wound specialist, dietician, therapy staff). Pain associated with wound care will be assessed and managed in accordance with provider. orders and pain management policies and procedures. IV. Treatment Decisions: Treatment decisions will be based on: Etiology of the wound: Pressure injuries. Non-pressure wounds (e.g., arterial, venous, diabetic, moisture-related skin damage). Surgical wounds. Incidental injuries/wounds (e.g., skin tear, medical adhesive-related injury). Atypical injury/wound (e.g., dermatological, or cancerous lesion, pyoderma,	F0684		05/01/2026

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F0684 SS = D	Continued from page 35 calciphylaxis). Characteristics of the wound: Pressure injury stage or level of tissue destruction if not a pressure injury. Size, including shape, depth, and presence of tunneling and/or undermining. Volume and characteristics of exudate. Presence of pain. Presence of infection or need to address bacterial bioburden. Condition of the tissue in the wound bed. Condition of peri-wound skin. Location of the wound; and Goals and preferences of the resident or their representative. Guidelines for dressing selection may be utilized in obtaining provider orders.	F0684		05/01/2026
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	F0880	Plan of Correction F880 SS=D Affected Resident(s): R3 has received new orders and is being monitored for signs and symptoms of infection. R3 care plan was reviewed and updated as needed to reflect current infection prevention interventions, including Enhanced Barrier Precautions (EBP) where applicable Potential Affected Resident(s): All residents have the potential to be affected. All residents on EBP have been reviewed to ensure they have the proper signage and PPE available, and	05/01/2026

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F0880 SS = D	Continued from page 36 services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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	F0880	Continued from page 36 care plans are up to date. Any identified gaps were immediately corrected. Measures/Systemic Changes: The Policies Infection Prevention and Control Program, Enhanced Barrier Precautions (EBP), and Hand Hygiene have been reviewed and remain current. All staff shall receive education on when to utilize handwashing/ hand hygiene and when to utilize enhanced barrier precautions. Monitoring: Hand Hygiene Audit to be completed on 3 licensed nursing staff when completing wound care 3 times a week for 2 weeks, then a minimum of 30 observations per month thereafter, or until substantial compliance is achieved. EBP Audit to be completed 3 times a week for 2 weeks, weekly for 4 weeks, then monthly for 3 months, or until substantial compliance is achieved. Results will be reported to QAPI. DON or designee is responsible for compliance. Date of Alleged Compliance: 5/01/2026	05/01/2026

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F0880 SS = D	Continued from page 37 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 proper handwashing/hand hygiene was implemented for 1 of 3 residents (R3) observed during wound care. In addition, the facility failed to ensure enhanced barrier precautions (EBP) were utilized during a transfer for 1 of 3 residents (R3). Findings include: R3's face sheet dated 3/27/26, identified diagnoses of diabetes, non-pressure chronic ulcer of right lower leg, and kidney transplant. R3's quarterly Minimum Data Set (MDS) dated 1/14/26, identified R3 had intact cognition, no behaviors, no rejection of care, needed partial/moderate assistance for transfers, was occasionally incontinent of bowel, has no pressure ulcers, had no venous or arterial ulcers, had no moisture associated skin damage, had an application of non-surgical dressing other than feet, application of ointment other than feet and received dialysis. R3's care plan dated 7/24/25, identified R3 needed EBP. Goal that staff will maintain enhanced barrier precautions when performing high contact resident care activities. Interventions as follows: -Don (apply) gown and gloves during wound care. (dated 7/24/25) -Don gown and gloves for the following high-contact resident care activities (dressing, bathing/showering, transferring, providing hygiene, changing linens, changing brief or assisting with toileting, catheter care.) (dated 7/24/25) R3's Wound Assessment dated 3/19/26, identified R4 had an open lesion on his right gluteus (group of muscles in the buttocks) that measured 0.5 centimeters (cm) x 0.74 cm. During an observation on 3/26/26 at 3:20 p.m., R3' room had a sign near the door that indicated R3 needed EBP for high contact care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing brief, or assisting with toileting, catheter care. During an interview on 3/26/26 at 3:22 p.m., nursing assistant (NA)-G stated R3 needed EBP (gown and	F0880		05/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245626	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Rehabilitation And Living Center	**1900 BALLINGTON BOULEVARD NW , ROCHESTER, Minnesota, 55901**

(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
F0880 SS = D	Continued from page 38 gloves) for high contact care activities because he had a wound on his right buttocks. During an observation and interview on 3/26/26 at 4:39 p.m., director of nursing (DON) was outside of R3's room, performed hand hygiene and applied a gown prior to entering R3's room. DON then entered R3's room where R3 was lying in bed. R3 was informed that a physician wanted to assess R3's right gluteal wound via a telehealth (video visit) in which R3 agreed. DON then placed the computer on R3's bed, went into the bathroom and applied gloves, without performing hand hygiene. DON then removed R3's brief and proceeded to remove a foam dressing that was near R3's right gluteal area. R3's foam dressing had stool on the left corner of the dressing. DON then placed the dressing in the trash, removed gloves, then applied new gloves, without performing hand hygiene prior to application of the new gloves. Surveyor intervened and asked DON when should hand hygiene/hand washing be done in which the DON stated hand hygiene should be done when hands/gloves are visibly soiled, before and after removing/applying gloves. DON confirmed she had not performed hand hygiene each time she had removed/applied gloves. DON then removed her gloves, performed hand hygiene, and applied new gloves. DON then completed the wound dressing change and performed hand hygiene appropriately. During an observation and interview on 3/27/26 at 7:31 a.m., R3 was seated in his chair in his room. An unknown nursing assistant (NA) who had a gown and gloves on then entered R3's room with a sit-to-stand mechanical lift. DON then applied the lift harness under R3's arms, cinched the waist strap while encountering R3's clothes in the process. DON then hooked up the harness to the machine, moved R3's left hand toward the handle on the lift with ungloved hands. DON and NA then transferred R3 to the bed when DON then pulled R3's pants down. R3 was then removed the harness while touching R3's clothes. Certified Nurse Practitioner Wound Nurse (CNP-WOC) then removed the dressing on R3's right gluteal area with gown and gloves on and assessed R3's wound and applied a new dressing. Hand hygiene was performed during the dressing change. DON then sat up R3 on the edge of the bed, touching his upper body with gown but no gloves, applied the lift harness under his arms and around R3's waist with a gown, but no gloves. R3 was then hooked up to the lift and as R3 stood, DON pulled up R3's pants and adjusted R3's shirt. Upon exiting R3's room, DON stated EBP was only needed if performing catheter or wound care and was not needed during	F0880		05/01/2026

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F0880 SS = D	Continued from page 39 transfers. DON then read the EBP sign that was outside of R3's room and identified that EBP was needed during any high contact resident care activities including transfers. Review of the facility's Enhanced Barrier Precautions Policy undated, identified It is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as a resident with wounds, indwelling medical devices or residents with "infection or colonization with an MDRO". The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of MDROs to employees' hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids. High-Contact Resident Care Activities include: Dressing Bathing/showering Transferring Providing hygiene Changing linens Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube. Wound care: any skin opening requiring a dressing." Procedure Standard Precautions should be applied to all residents at all times. Transmission-based precautions should be applied to all residents when standard precautions alone do not prevent pathogen transmission. Enhanced Barrier Precautions are to be implemented in addition to Standard Precautions when other Transmission-Based precautions do not apply, when facility identifies any resident with:	F0880		05/01/2026

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F0880 SS = D	Continued from page 40 MDRO infection or colonization when Contact Precautions do not otherwise apply. If resident is infected or colonized with any MDRO and has secretions or excretions that are unable to be covered or contained, the resident should be placed on contact precautions. Wounds or skin openings such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers Shorter-lasting wounds such as skin breaks or skin tears covered with an adhesive bandage would not need Enhanced Barrier Precautions Any indwelling medical device, regardless of MDRO colonization status, for example: Central lines Peripheral intravenous line is not considered an indwelling medical device for the purposes of EBP.”2 Urinary catheters Feeding tubes Tracheostomy/ventilator Personal Protective equipment is required for all staff providing high-contact resident care activities to include: Gown and gloves with: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care:any skin opening requiring a dressing.”	F0880		05/01/2026

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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 3/24/26, 3/25/26, 3/26/26, and 3/27/26 a complaint 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 licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed. H56269020C	20000		04/23/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29822	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/27/2026

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20000	Continued from page 1 (2807600) and H56269061C (2808514) with a licensing order issued at 900, 830, 570,1390 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 surveyor's 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 14-01, available at 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	20000		04/23/2026
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	20570	Date of Alleged Compliance: 5/01/2026	05/01/2026

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20570	Continued from page 2 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 comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to timely revise the care plan to include an individualized toileting/incontinence plan for 1 of 3 residents (R1) who were reviewed for impaired skin integrity that had impaired skin integrity. Findings include: R1’s face sheet dated 3/27/26, identified diagnoses of primary progressive multiple sclerosis, hereditary spastic paraplegia, obesity, pressure induced deep tissue damage to left heel. R1’s Significant Change Minimum Data Set (MDS) dated 2/26/26, identified R1 had intact cognition, no behaviors, no rejection of care, dependent for toileting hygiene, had lower extremity limitation of range of motion, used a wheelchair, substantial/maximum assistance to roll left and right in bed, dependent for transfers, did not ambulate, occasionally incontinent of urine, always continent of bowel, was at risk for pressure ulcers, had one or more unhealed pressure ulcers/injuries, had one unstageable pressure ulcer that was not present on admission, no arterial/venous ulcers, had moisture associated skin damage (MASD), had pressure reducing device for chair and bed, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care, had application of non-surgical dressing other than feet, application of ointments/medication other than feet, had application of dressings to feet. R1’s Skin focus care plan revised on 2/24/26, identified R1 had an actual pressure injury related to MS, increased need of activities of daily living (ADL) assistance with mobility, history of ulcer prior to admission and a deep tissue injury to left heel identified on 1/8/26. Goal to show no complications in skin integrity. Interventions as follows: -Inspect skin daily with cares. (dated 10/31/25) -Follow wound care orders. (Dated 11/11/25)	20570		05/01/2026

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20570	Continued from page 3 -Weekly skin checks completed by nursing. (dated 12/15/25) -Pressure ulcer care to left heel as ordered. (dated 1/15/26) -Nutritional supplements per dietician order to support wound healing. (Dated 2/2/26) -Gel mattress applied 2/13/26. (dated 2/16/26). R1's care plan did not include an individualized toileting plan. R1's Nursing Weekly Skin Check dated 3/3/26, identified R1 had a new stage 2 pressure ulcer on her coccyx with measurements of 1.84 centimeters (cm) x 1.14 cm and contact dermatitis on left and right gluteal fold. R1's IDT Final Post Review Follow Up dated 3/10/26 however was signed on 3/23/26, identified R1's new skin issue (did not identify what skin issue). Interventions were put in place after incident that team reviewing were wound care treatment ordered, repositioning and incontinent care increased. Effectiveness of the interventions put in place after the incident is that resident will refuse repositioning, though staff are still encouraging. R1's care plan did not reflect a revision to include any repositioning schedule nor incontinence care increased until 3/17/26 (seven days after the IDT review). Review of R1's care plan from 3/3/26 through 3/16/26 did not identify revisions pertaining to increased incontinence care. R1's progress note dated 3/17/26 at 5:00 p.m., identified R1 had a decline in her wound characteristics. R1 agreed to have staff come in and reposition her every 2 hours from her left to her right side. R1also stated she did not want to use the bed pan anymore and agreed to use the bedside commode for toileting needs. Email was sent to the nurse practitioner and wound nurse. Primary nurse practitioner will be in house tomorrow and will assess the wound. Air mattress was placed on R1's bed. R1's Skin Issue progress note dated 3/17/26, identified an evaluation of R1's middle coccyx wound. Issue type listed as a Kennedy Terminal Ulcer/End of Life. Progress listed as deteriorating; wound characteristics listed as deteriorated; Pressure ulcer staging as a Stage 4 pressure ulcer; wound in house acquired; increase in exudate	20570		05/01/2026

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20570	Continued from page 4 (drainage); increase in size and smell; pain described as sharp; measurements recorded as 4.11 cm x 7.93 cm x 1.0 cm; no tunneling; 10% slough; 90% eschar; moderate drainage that was seropurulent (thin, watery, cloudy wound discharge that is yellow to tan or pink in color indicating early signs of infection); surrounding tissue with erythema (redness); with moderate dressing saturation. R1's skin focus care plan was revised on 3/17/26 to include the following: -Provide prompt incontinence care and keep skin clean and dry to prevent moisture related skin breakdown. R1's elimination focus care plan revised on 3/17/26, identified R1 had incontinence due to neurogenic bladder. Goal to cooperate in establishing a routine for urine elimination. Interventions as follows: -Use bedside commode and no longer use the bedpan. -Offer bedside commode every 2-3 hours and as needed. Able to state when need to use the bathroom and will also ask for assistance. During an interview on 3/24/26 at 3:57 p.m., nursing assistant (NA)-D stated when she worked with R1 she would sometimes fall asleep on the bedpan and forget to ask for staff to take her off, however, NA-D stated staff should be aware if they placed a resident on a bedpan to ensure to take them off in a timely manner to prevent a sore from developing. NA-D had not heard R1 was not supposed to use the bedpan until after her sore had already worsened. During an interview on 3/25/26 at 4:11 p.m., DON stated R1care plan had not been revised to include a turning and repositioning schedule, nor did her toileting care plan revised to not have R1 use the bedpan until 3/17/26. DON explained R1's care plan should have been revised as soon as she heard that R1 was falling asleep while sitting on the bedpan and not waited until 3/17/26 until after R1's pressure ulcer had worsened. Review of the facility's Comprehensive Care Plan Policy dated 4/11/25. Identified The purpose of this policy is to ensure that all residents receive individualized, person-centered care through the timely development, implementation, and ongoing review of comprehensive care plans. This policy ensures alignment with federal regulations and	20570		05/01/2026

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20570	Continued from page 5 professional standards by outlining processes that assess resident needs and preferences, coordinating interdisciplinary team input, and promoting culturally competent and trauma-informed care. Development of the Care Plan. The comprehensive care plan must be: (a) Developed both: Within seven (7) days after completion of the comprehensive assessment, and Within 21 days after the resident's admission. (b) Prepared by an IDT that includes but is not limited to: The attending physician or, if unavailable, the designated non-physician practitioner (NPP) who is involved in the resident's care, to the extent permitted by state law. A registered nurse with responsibility for the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (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 director of nursing 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		05/01/2026
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document	20830	Date of Alleged Compliance: 5/01/2026	05/01/2026

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20830	Continued from page 6 review the facility failed to comprehensively assess an area of moisture associated skin damage and failed to notify the physician for 1 of 1 resident (R3) reviewed for non-pressure skin issues. Findings include: R3's face sheet dated 3/27/26, identified diagnoses of diabetes, Crohn's disease, and kidney transplant. R3's quarterly Minimum Data Set (MDS) dated 1/14/26, identified R3 had intact cognition, no behaviors, no rejection of care, needed partial/moderate assistance for transfers, was occasionally incontinent of bowel, has no pressure ulcers, had no venous or arterial ulcers, had no moisture associated skin damage, had an application of non-surgical dressing other than feet, application of ointment other than feet and receives dialysis. R3's Wound Assessment dated 2/26/26, identified R3 had a resolved moisture associated skin damage (MASD) to his right gluteus. R3's progress note dated 3/9/26, identified sacral wound cleansed and creams applied to sacrum as well. Sores are still open and present and R3 experienced pain with application of creams. R3's record did not identify measurements of the wounds or any other wound characteristics, nor evident of physician notification. R3's Wound Assessment dated 3/12/26, identified R3 had an open lesion to the right gluteus that measured 0.3 centimeters (cm) x 0.21 cm. R3's wound assessment did not identify the type of wound nor other wound characteristics. R3's record did not identify physician had been notified or any treatment for open lesion. R3's Wound Assessment dated 3/19/26, identified R3 had an open lesion to the right gluteus that measured 0.6 cm x 0.74 cm. No other characteristics were documented. R1's progress note dated 3/20/26, identified nurse practitioner in facility to assess R3's right gluteal fold wound. NP is going to send new orders for wound care via fax. Instructed to cleanse, apply skin prep to surrounding tissue, apply Medihoney (an ointment that supports the removal of necrotic tissue and aids in wound healing) to wound bed and cover with foam dressing. R3's nurse practitioner note dated 3/20/26, identified R3 had a stage 3 pressure ulcer on left	20830		05/01/2026

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20830	Continued from page 7 buttocks that measured 1.0 cm x 0.3 cm x less than 0.2 cm with 100% slough (yellow-tan necrotic tissue) in wound bed. Plan to cleanse daily with wound cleanser, pat dry, apply MediHoney to open wound, apply skin prep to peri wound, cover with 2 x 2 protective foam bordered dressing. Turn and reposition frequently and have dietician evaluate for nutrition support and wound healing. R3's physician orders identified the following order: -Cleanse buttocks and pat dry, apply house barrier cream twice daily and as needed for incontinence cares. (3/5/26 through 3/20/26) -Left buttocks: Cleanse with wound cleanser, apply Medihoney to open wound, apply skin prep to peri wound, cover with 2 x 2 protective foam dressing, change daily and as needed at bedtime. (dated 3/20/26) R1's record did not identify a treatment to the right gluteus wound. R3's progress note dated 3/24/26, identified a nutrition/dietary had a review of R3 due to new wound on gluteus that per registered nurse (RN) was considered a stage 2. R3's progress note dated 3/24/26 at 1:00 p.m., identified an email sent to the nurse practitioner (NP) wanting to follow up on the staging of a previously moisture associated skin damage to R3's right gluteal area that was staged as a stage 3 pressure ulcer. Will wait for a response from NP regarding wound classification. During an interview on 3/26/26 at 1:45 p.m., director of nursing (DON) stated she had sent an image of R3's right gluteal wound to the nurse practitioner to evaluate prior to doing rounds on 3/20/26. DON explained R3's wound had not had a notification or gotten treatment until 3/20/26 and the physician should have been notified as soon as the wound was identified. DON was unaware the NP had labeled R3's wound as his left buttocks when it was his right gluteal area nor that it was classified as a stage 3 pressure ulcer. DON believed the wound may be moisture associated skin damage and was reaching out to a different provider to assist with the determination of the wound. During an interview on 3/26/26 at 2:12 p.m., medical director (MD) stated he had received a call from the facility to review an image of R3's right gluteal wound to assist with classification of the wound. MD	20830		05/01/2026

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20830	Continued from page 8 stated he will be doing a telehealth video visit today (3/26/26) to assess R3's wound on his right gluteal area to see if he would be able to classify what type of wound it was. During an interview on 3/26/26 at 4:30 p.m., R3 stated he has this recurring area on his right buttocks that is painful. R3 stated he leaked stool ever since he had surgery a long time ago and staff put a special pad near his rectum to try and catch the stool. R3 got a special cushion for his wheelchair seat but a "donut" cushion for his chair was on order to help his bottom not hurt so bad. Just waiting for it to be delivered. During an observation and interview on 3/26/26 at 4:39 p.m., DON performed a telehealth visit with the medical director (MD) to assess R3's right gluteal wound. DON removed R3's brief where a foam dressing was on R3's right gluteus. DON removed the dressing where an approximately 0.5 cm x 0.5 cm open wound was present over what appeared to be a scar- pink skin was noted at the base of the wound, with maceration (occurs when the skin is exposed to moisture for too long) surrounding the wound. R3 stated he had an anal fistula (a tunnel that develops between the inside of the anus and the outside of the skin) repair over 40 years ago and had leaked stool ever since and believed it was in that same area of the wound. MD then assessed R3's wound and explained that the wound was not pressure related, and he would classify the wound as MASD due to the continued leaking stool and wanted to continue the current treatment and have the certified wound nurse practitioner evaluate the wound the next day to give further recommendations. During an interview on 3/26/26 at 5:15 p.m., registered nurse (RN)-D stated R3's wound was never on his left buttocks, however, the wound orders were for the left buttocks, but she just thought it was a mistake and had been applying the treatment to the right gluteal open area since there was no open area on the R3's left buttocks. During an interview on 3/26/26 at 2:01 p.m., director of nursing (DON) stated R3's right gluteus wound was identified as an open lesion, due to not "feeling comfortable" in being able to assess the type of wound R3 had on his buttocks. DON stated when the NP assessed the wound on 3/20/26 she identified it on the left buttocks, which was incorrect	20830		05/01/2026

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20830	Continued from page 9 due to the wound his right gluteus that was assessed and as a stage 3 pressure ulcer and gave orders. DON initially thought the wound was a stage 2 pressure ulcer, but after review of R3's chart identified R3 had a history of MASD in the same areas in February. DON stated she relied on the certified wound nurse to assist with staging or to identify the type of wound, however, had not reached out to get clarification on R3's wound type. During an observation and interview on 3/27/26 at 7:31a.m., certified nurse practitioner wound nurse (CNP-WOC) assessed R3's right gluteal wound and classified the wound as MASD and changed the treatment order to the following: wash with normal saline, pack wound with collagen (wound dressing that promotes healing by stimulating new tissue growth), cover with foam, change daily and as needed soiling, may use barrier cream to surrounding peri wound for redness or irritation. Review of the facility's Wound Treatment Policy dated 1/21/26, identified Residents with wounds will receive necessary treatment and services, in accordance with provider orders and professional standards of practice, to promote healing, prevent infection, and prevent the development of new wounds unless clinically unavoidable. Wound treatment will be delivered using evidence-based practices, individualized to each resident's assessed needs, and documented, monitored, and reviewed to ensure effectiveness and regulatory compliance. I. General Requirements: Based on the comprehensive assessment of a resident, the facility will ensure that residents with pressure injuries and other types of wounds receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent the development of new wounds unless clinically unavoidable. Wound treatment and monitoring will be: Individualized based on the wound's etiology, contributing factors, and the residents. overall condition, goals, and preferences. In accordance with the residents' comprehensive	20830		05/01/2026

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20830	Continued from page 10 care plan; and Consistent with professional standards of practice. II. Comprehensive Wound Assessment: A comprehensive assessment will be completed for each wound to determine etiology and contributing factors. This assessment will include: Underlying causes of the wound (e.g., pressure, shear, friction, vascular insufficiency, moisture, trauma, or other etiology); Contributing conditions or risk factors (e.g., nutrition, hydration, perfusion, mobility, incontinence, comorbidities, medications); and Consistent measurement of wound characteristics, including location, size, depth, tunneling, undermining, exudate, tissue type, and condition of the peri-wound skin. III. Treatment Orders: Wound treatments will be provided in accordance with provider orders, including: The cleansing method, Type of dressing, and Frequency of dressing changes. In the absence of treatment orders, the licensed nurse will notify the provider to obtain. orders. This may be the designated treatment nurse or the assigned licensed nurse in the absence of the treatment nurse. Treatment orders will be guided by current evidence-based wound care practices and interdisciplinary input when needed (e.g., wound specialist, dietician, therapy staff).	20830		05/01/2026

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20830	Continued from page 11 Pain associated with wound care will be assessed and managed in accordance with provider. orders and pain management policies and procedures. IV. Treatment Decisions: Treatment decisions will be based on: Etiology of the wound: Pressure injuries. Non-pressure wounds (e.g., arterial, venous, diabetic, moisture-related skin damage). Surgical wounds. Incidental injuries/wounds (e.g., skin tear, medical adhesive-related injury). Atypical injury/wound (e.g., dermatological, or cancerous lesion, pyoderma, calciphylaxis). Characteristics of the wound: Pressure injury stage or level of tissue destruction if not a pressure injury. Size, including shape, depth, and presence of tunneling and/or undermining. Volume and characteristics of exudate. Presence of pain. Presence of infection or need to address bacterial bioburden. Condition of the tissue in the wound bed. Condition of peri-wound skin. Location of the wound; and Goals and preferences of the resident or their representative.	20830		05/01/2026

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20830	Continued from page 12 Guidelines for dressing selection may be utilized in obtaining provider orders. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to monitoring, assessing, implementations for non-pressure skin related issues are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		05/01/2026
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to monitor, comprehensively assess, develop, and implement individualized interventions to prevent/mitigate the risk of pressure ulcers and/or deterioration for 3 of 4 residents (R1, R4, R5) reviewed for pressure ulcers. This caused actual harm to R1 who developed an avoidable unstageable pressure ulcer on her coccyx which needed surgical debridement and hospitalization.	20900	Date of Alleged Compliance: 5/01/2026	05/01/2026

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20900	Continued from page 13 Findings include: Based on observation, interview, and document review the facility failed to monitor, comprehensively assess, develop, and implement individualized interventions to prevent/mitigate the risk of pressure ulcers and/or deterioration for 3 of 4 residents (R1, R4, R5) reviewed for pressure ulcers. This caused actual harm to R1 who developed an avoidable unstageable pressure ulcer on her coccyx which needed surgical debridement and hospitalization. Findings include: Pressure Ulcer/Injury (PU/PI) is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury occurs because of intense and/or prolonged pressure or pressure in combination with shear. “Eschar” is dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound. i Stage 2 Pressure Ulcer: Partial thickness skin loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss.	20900		05/01/2026

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20900	Continued from page 14 Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable PU/PI. Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration: Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur. Moisture Associated Skin Damage: inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, sweat, wound drainage, saliva or mucus. R1's face sheet dated 3/27/26, identified diagnoses of primary progressive multiple sclerosis (MS), hereditary spastic paraplegia, obesity, pressure induced deep tissue damage to left heel. R1's nursing home nurse practitioner (NP) note dated 2/6/26, identified R2 had a stage 2 pressure ulcer on left buttocks that had resolved and a deep tissue injury to the left heel.	20900		05/01/2026

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20900	Continued from page 15 R1's hospital discharge summary dated 2/24/26, identified R1 had been hospitalized for an insertion of a pain management pump. R1 had a preexisting pressure induced deep tissue damage to the left heel and a new gluteal cleft lesion for which the wound nurse had been consulted. R1's hospital after visit summary (AVS) dated 2/24/26, identified R1 had irritant contact dermatitis on her bilateral gluteal cleft and had treatment to cleanse area twice daily and apply barrier cream three times per day and as needed. R1's Braden Scale for Prediction of Pressure Ulcer Risk Evaluation dated 2/24/26, identified R1 was high risk for developing pressure ulcers due to being slightly limited to respond to verbal commands, cannot always communicate discomfort or need to be turned, being constantly moist, chairfast, very limited mobility due to making only slight changes in body or extremity position but unable to make frequent or significant changes independently, probably inadequate nutrition, and potential problem with friction and shear. R1's ADL focus care plan dated 10/31/25, identified R1 triggered in ADL's because she had preferences and other items of need. Goal to maintain current level of ADLs. Interventions as follows: -Assist of two for bed mobility. (dated 2/24/26) -Assist of two using full body mechanical lift for transfers. (dated 2/24/26) R1's physician orders identified an order dated 11/7/25 to frequent every 2 hours repositioning for wound care. R1's Skin focus care plan revised on 2/24/26, identified R1 had an actual pressure injury related to MS, increased need of activities of daily living (ADL) assistance with mobility, history of ulcer prior to admission and a deep tissue injury to left heel identified on 1/8/26. Goal to show no complications in skin integrity. Interventions as follows: -Inspect skin daily with cares. (dated 10/31/25) -Follow wound care orders. (Dated 11/11/25) -Weekly skin checks completed by nursing. (dated 12/15/25)	20900		05/01/2026

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20900	Continued from page 16 -Pressure ulcer care to left heel as ordered. (dated 1/15/26) -Nutritional supplements per dietician order to support wound healing. (Dated 2/2/26) -Gel mattress applied 2/13/26. (dated 2/16/26) R1's Nursing Data Collection Admission/Readmission form dated 2/24/26, identified an unstageable pressure ulcer on left heel that was present on admission/readmission, with no measurements or characteristics of the wound. R1 also had contact dermatitis of the left and right gluteal fold, with no measurements or characteristics. Nursing Data Collection identified R1 could not reposition while lying in bed, did not ambulate, not able to reposition when sitting in chair or wheelchair, had a pressure reducing wheelchair cushion in place and had a pressure reducing mattress. R1's Significant Change Minimum Data Set (MDS) dated 2/26/26, identified R1 had intact cognition, no behaviors, no rejection of care, dependent for toileting hygiene, had lower extremity limitation of range of motion, used a wheelchair, substantial/maximum assistance to roll left and right in bed, dependent for transfers, did not ambulate, occasionally incontinent of urine, always continent of bowel, was at risk for pressure ulcers, had one or more unhealed pressure ulcers/injuries, had one unstageable pressure ulcer that was not present on admission, no arterial/venous ulcers, had moisture associated skin damage (MASD), had pressure reducing device for chair and bed, nutrition or hydration intervention to manage skin problems, pressure ulcer/injury care, had application of non-surgical dressing other than feet, application of ointments/medication other than feet, had application of dressings to feet. R1's Nursing Weekly Skin Check dated 2/27/26, identified R1 had an unstageable pressure ulcer to the left heel and contact dermatitis to the left and right gluteal fold. Weekly Skin Check did not identify measurements or other wound characteristics. Review of R1's Treatment Administration Record (TAR) from 2/1/26 through 2/28/26, included a physician order dated 11/7/25 to reposition R1 every 2 hours. Documentation noted one refusal marked on 2/12/26 at 2:00 a.m. Repositioning not signed off on 2/25/26 at 8:00 a.m.; 2/26/26 at	20900		05/01/2026

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20900	Continued from page 17 10:45 p.m.; and 2/27/25 at 10:45 p.m. R1's Nursing Weekly Skin Check dated 3/3/26, identified R1 had a stage 2 pressure ulcer on her coccyx with measurements of 1.84 centimeters (cm) x 1.14 cm (no depth was documented even though the record identified the wound as stage 2 pressure ulcer.) Additional wound was unstageable pressure ulcer on left heel that measured 2.29 cm x 2.15 cm x 0.1 cm. (no other characteristics included). Contact dermatitis on left and right gluteal fold (no measurements or further description included). Comment of new coccyx pressure ulcer stage 2 and will be seen by wound nurse tomorrow. R1's record identified a Situation, Background, Assessment, Response (SBAR) dated 3/3/26 to inform physician of stage 2 pressure ulcer on coccyx. Nursing intervention to cleanse with normal saline, place Mepilex (name brand of foam) dressing to area daily (in accordance with facility standing orders) and as needed if soiled or dislodged. Also stated need recommendations for "restriction" 30 degrees so resident is not bedbound. SBAR also indicated that will talk with R1 about adding back air mattress. SBAR did not indicate measurements of wound, nor any other wound characteristics. During an interview on 3/25/26 at 9:32 a.m., environmental services director (ESD) stated his department moved R1 to a different room on 3/4/26, however, the gel mattress never got moved to her new bed. R1's Interdisciplinary Team (IDT) Team Initial Post Investigation Review dated 3/5/26 at 12:00 p.m., identified a new skin condition from 3/3/26 in which after the review of investigation the IDT's root cause of the incident was that R1 was staying in bed more often, per choice and is incontinent of bowel and bladder and is extensive assistance with bed mobility, unable to make micro-shifts. R1's care plan was reviewed and root cause identified. R1 was high risk for skin breakdown due to reasoning as the forementioned. Treatment interventions are put in place and carried out. R1's Wound Nurse Practitioner visit note dated 3/5/26, indicated reason for visit was wound follow up of left heel and a new coccyx wound. R1's heel continues to improve and is nearly closed, has a new open area on her bottom. R1 spends a lot of time in bed and encouraged to offload when in bed	20900		05/01/2026

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20900	Continued from page 18 and wheelchair. The area is over a bony prominence and appears to be pressure related. Plan for coccyx wound was to cleanse and pat dry and cover with foam dressing, air mattress, pressure offloading, dietician consult for wound supplement recommendations. Review of R1's record from 3/3/26 through 3/16/26 identified the care plan had not been revised nor evident that an air mattress had been placed on R1's bed per wound nurse recommendations on 3/5/26. Review of R1's TAR from 3/1/26 through 3/20/26, identified a physician order dated 11/7/25 to reposition every 2 hours; did not identify R1 had any refusals of repositioning, however, repositioning had not been signed off as completed on 3/2/26 at 10:45 p.m. R1's Incontinence focus care plan revised on 11/3/25, identified R1 had altered elimination, needed treatment/monitoring/cares due to neurogenic bladder. Corresponding interventions dated 11/12/25 directed to empty Purewick (external urine collection system) and on 12/4/25 directed to Change Purewick cannister per order. R1's IDT Final Post Review Follow Up dated 3/10/26 (signed on 3/23/26), identified R1's new skin issue (did not identify what skin issue). Interventions were put in place after incident that team reviewing were wound care treatment ordered, repositioning and incontinent care increased. Effectiveness of the interventions put in place after the incident was documented as resident will refuse repositioning, though staff are still encouraging. R1's care plan did not reflect revision for any increases in repositioning since 11/7/25, nor did the incontinence care get increased, and not evident an individualized toileting program or schedule was developed and implemented. During an interview on 3/25/26 at 4:11 p.m. director of nursing (DON) explained the 3/10/26 IDT Final Post Review follow up indicated there would be an increase in incontinence care because she had heard R1 had been falling asleep on the bed pan, however, R1's care plan had not been revised to reflect she should not use the bedpan and should be using a commode instead. R1's Skin Issue Wound Assessment dated 3/12/26, identified R1 had a pressure ulcer/injury to middle coccyx that was stable: previously	20900		05/01/2026

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20900	Continued from page 19 deteriorating; was in house acquired with onset date of 3/2/26. The assessment identified coccyx wound measurement of 1.79 cm x 4.03 cm which indicated worsening from the previous assessment on 3/3/26 measurement of 1.84 cm by 1.14 cm. The 3/12/26 assessment also described the wound as no tunneling, surrounding skin fragile, and no exudate. The assessment did not include any other characteristics. R1’s coccyx wound’s corresponding image taken 3/12/26, identified a large dark purple line on the left buttocks that extended to the right side of the buttocks. An unopened blister was noted on the left buttocks near the lateral part of the purple area. R1’s skin surrounding the wound was red in color. During an interview on 3/25/26 at 11:14 a.m., registered nurse case manager (RN-CM) stated she assessed R1’s coccyx wound on 3/3/26 and 3/12/26, however, during the 3/12/26 assessment R1's wound appeared stable to her. RN-CM confirmed R1's wound had increased in size and had a change in color which could indicate the wound was beginning to worsen. RN-CM stated the purple discoloration in the image did not appear as purple to her but more of a brown color and appeared more like a “scab”. RN-CM could not identify the type of wound associated with the purple discoloration she had documented on the 3/12/26 assessment. RN-CM indicated during the assessment she did not identify R1’s bed did not have the gel mattress according to the care plan. RN-CM reported she did not notify the physician of the increase in size of the wound or the change in color. During an interview on 3/25/26 at 4:11 p.m., DON stated RN-CM described R1’s coccyx wound to her on 3/12/26, and by the description she believed that R1’s coccyx wound had begun to change. DON explained she had instructed RN-CM to notify the physician; however, DON had not evaluated the wound herself to see what the changes were. DON further explained she had not followed up to ensure that the physician had been notified nor evaluated if R1’s pressure relieving interventions were effective. DON reviewed R1’s record and explained R1’s wound assessment that had been completed on 3/12/26 showed a change in R1’s wound from previous assessments showing deterioration. DON further explained R1’s wound had not been staged in the assessment and should have been identified as a deep tissue injury. DON stated the physician should have been notified and R1’s turning and repositioning schedule should	20900		05/01/2026

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20900	Continued from page 20 have been reevaluated/increased, however, was not completed. R1's progress note dated 3/16/26 at 10:25 p.m., identified after R1's bath skin was assessed and noticed that coccyx area was dark purple/black in color with an odor. R1's record did not identify any other characteristics of the wound including measurements nor physician notification of newly identified discoloration. R1's progress note dated 3/17/26 at 4:41 p.m., was called to R1's bedside due to change sacral dressing due to soilage. Wound noted to be increased in size and drainage noted. Management updated. R1's progress note dated 3/17/26 at 5:00 p.m., identified R1 had a decline in her wound characteristics. R1 agreed to have staff come in and reposition her every 2 hours from her left to her right side (which was the original treatment order dated 11/7/25, identifying no increase in frequency). R1also stated she did not want to use the bed pan anymore and agreed to use the bedside commode for toileting needs. Email was sent to the nurse practitioner and wound nurse. Primary nurse practitioner will be in house tomorrow and will assess the wound. Air mattress was placed on R1's bed. During a follow up interview on 3/25/26 at 12:15 p.m., ESD explained a request had been made on 3/17/2 to place an air mattress on R1's bed, however, the maintenance staff mistakenly marked off that it was completed prior to being placed and R1's air mattress had not been placed on her bed until 3/18/26. According to an earlier interview on 3/25/26 at 9:32 a.m. ESD indicated that's when we found out the gel mattress had not moved to the new room with her on 3/4/26. R1's Skin Issue progress note dated 3/17/26, identified an evaluation of R1's middle coccyx wound. Issue type listed as a Kennedy Terminal Ulcer/End of Life stage 4 pressure ulcer that was in house acquired. The note identified the wound was deteriorating (from the previous assessment 3/12/26 noted 1.79 cm x 4.03 cm.) measurements on 3/17/26 documented as 4.11 cm x 7.93 cm x 1.0 cm; no tunneling; 10% slough; 90% eschar; moderate drainage that was seropurulent (thin, watery, cloudy wound discharge that is yellow to tan or pink in color indicating early signs of infection); surrounding tissue with erythema (redness); with moderate dressing saturation and	20900		05/01/2026

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20900	Continued from page 21 pain described as sharp. R1's progress note dated 3/17/26, identified wound assessment dated 3/17/26, documented as a "Kennedy Terminal Ulcer/End of Life." Upon further clinical review, R1 was not actively dying and did not meet the criteria for a Kennedy Terminal Ulcer. R1's wound was more consistent with a pressure injury related to immobility, moisture exposure, and high-pressure injury risk. The wound will be managed according to the facility pressure injury protocol and wound care recommendations. Wound measurements, staging, and treatment orders remain accurate and ongoing monitoring will continue. R1's skin focus care plan was revised 3/17/26 to include the following interventions: -Turn and reposition every 2 hours and as needed, with continued staff encouragement and education if declines. -Provide prompt incontinence care and keep skin clean and dry to prevent moisture related skin breakdown. -Provide coccyx wound care as ordered. R1's elimination focus care plan revised on 3/17/26 to include the following interventions: -Use bedside commode and no longer use the bedpan. -Offer bedside commode every 2-3 hours and as needed. Able to state when need to use the bathroom and will also ask for assistance. During an interview on 3/25/26 at 4:11 p.m., DON stated on 3/17/26 R1's toileting care plan had been revised to not use the bedpan because she had heard from staff that R1 was falling asleep while sitting on the bedpan and this likely caused the development of a deep tissue injury on 3/12/26. DON explained that R1's care plan should have been revised at the time she heard about R1 falling asleep on the bedpan and not waited until R1's wound worsened on 3/17/26. R1's nurse practitioner note dated 3/18/26, identified nursing had notified NP about wound concerns with a worsening wound to coccyx.	20900		05/01/2026

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20900	Continued from page 22 New orders to wound to cleanse with normal saline, pat dry, apply skin prep to surrounding intact skin, apply iodosorb (a sterile antimicrobial wound dressing used to remove slough/debris and killing bacteria) mixed with hydrogel to open wound, place foam dressing, change daily and as needed if soiled or dislodged. Nursing had implemented a scheduled offloading pressure every 2 hours and will no longer be using a bedpan. R1 now has an air mattress to relieve pressure. Review of R1's care plan identified the additional intervention of the air mattress on 3/18/26. During an interview on 3/25/26 at 4:11 p.m., DON stated she thought the NP was going to physically assess R1's buttock wound on 3/18/26, however, the NP only reviewed image from 3/17/26 and gave orders. R1's progress note dated 3/18/26 at 8:51p.m., identified R1's wound had an increase in foul smelling odor and pain increased since yesterday assessment. R1 continues to have blanchable redness to surrounding skin, wound bed with 90% necrotic (dead, non-viable tissue) tissue and 10% slough (yellow or white, soft that delays healing). Call placed to on-call physician to update on wound characteristics and will await call back. R1's Emergency Department (ED) Telemedicine (the use of delivery of healthcare services from a distance using a computer) note dated 3/18/26 at 9:38 p.m., identified R1 had been seen due to a sacral wound that has changed significantly in the past 48 hours with concern for infection as well as the skin around the wound seems red. Noted foul smell to the wound, normal vital signs, and not complaints related to the wound. Assessment identified that the wound was the size of the palm, wound itself is dark which was consistent with an eschar, surrounding redness that is blanchable. Area feels firm to nursing at bedside and wound itself is dry. The wound itself is expanding which is a concern given R1's ambulatory status, but it is difficult to ascertain whether the surrounding tissue is due to expansion of the wound and is not a stage 1 versus infection. Given the wound is dry and the patient remains clinically stable, elected not to transfer to the ED and will have wound assessed by the in-house provider tomorrow morning. ED note stated if the provider is not able to arrange for a provider to assess R1 at bedside in the morning, she will be transferred to the ED for evaluation at that time.	20900		05/01/2026

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20900	Continued from page 23 R1's progress note dated 3/19/26 at 10:17 a.m., identified that a call placed to physician asking to have a provider to assess R1's wound. Note received from physician assistant regarding response from situation, background, assessment, and recommendation (SBAR) that was sent on 3/19/26. Electronic health record reviewed to include photo of wound taken 2 days prior (3/17/26), telehealth ED visit and phone call with an on-call provider. Response to SBAR sent was as followed: known difficulties assessing skin condition with telehealth visits, therefore, given lack of symptoms and photo from two days ago does show surrounding redness, not of concern at that time, will not send to the ED at this time. Orders to continue current wound treatment as ordered on 3/18/26. Continue scheduled offloading. Check vital signs every shift for 5 days. R1's progress note dated 3/19/26 at 10:22 a.m., identified writer talked with R1 regarding providers decision to wait until tomorrow and nursing to continue monitoring. Wound culture had been requested due to foul smelling odor, eschar to the wound with black/mixed purulent drainage, increase drainage and increase in pain from 3/17/26. During an interview on 3/25/26 at 4:00 p.m., DON stated on 3/19/26 she had sent an SBAR to see if a physician could assess R1's wound in person as per the Tele ED recommendations because the certified wound nurse practitioner had not been available to assess R1's buttocks wound. DON explained that the physician assistant sent back a response to continue to monitor in facility and not send R1 to the ED for evaluation. DON explained she felt R1's wound appeared infected and needed to be seen in the ED, but since the physician assistant declined to give an order to send to the ED, they continued to monitor R1 in the facility. DON confirmed that the facility had an order to send R1 to the ED if a physician could not see R1 in person on 3/19/26, however, did not send her to the ED for her possible infected wound and she should have just been sent. R1's nurse practitioner note dated 3/20/26, identified R1 had been seen for assessment of an unstageable (deep tissue injury) pressure wound that was contiguous (sharing a common border, touching, or being in proximity) site of back buttocks and hip. Nursing was concerned for	20900		05/01/2026

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20900	Continued from page 24 infection and over the past 3 days the wound had increased in size and was malodorous (having an unpleasant, foul, or stinky smell). R1was afebrile (without fever) and declined pain. Dressing removed and had a large amount of purulent malodorous drainage; peri-wound was erythematous (redness) with area of eschar expanded in the past 3 days. Concern for infection and gave orders to send R1 to emergency department (ED) for further evaluation and management. R1's progress note dated 3/20/26, identified R1 left facility at 11:20 am with emergency management services. R1's ED note dated 3/20/26, identified R1 presented for concerns for an infected coccygeal wound. R1 had a large irregular wound over the coccyx with eschar and a little bit of slough. Redness to the left glute that is warm and firm. Yellowish drainage that was foul smelling on the dressing. R1 was afebrile and hemodynamically stable. R1 was admitted for consideration of wound debridement and antibiotics. Computed tomography (CT) did not identify a discrete abscess or suggestion of osteomyelitis. Impression was sacral decubitus ulcer with associated left gluteal soft tissue phlegmons (a severe, spreading, non-encapsulated bacterial inflammation of soft tissue) with no evidence of osteomyelitis. R1's hospital History and Physical Hospital note dated 3/20/26, identified R1 was admitted for concerns for an unstageable pressure ulcer. A couple of days ago, nursing staff had a ED telemedicine activated and recommended short term in-person follow up. Evaluation revealed the wound note to be foul smelling with a large necrotic area surrounded by erythema (redness). R1 will need debridement of this large wound. R1 was treated empirically with intravenous antibiotics. R1's hospital note dated 3/21/26, identified R1 had surgical debridement on 3/21/26. R1 had new and worsening anemia with studies consistent with anemia or chronic disease. R1's A1C was markedly elevated which although confounded her anemia may explain the fast worsening of her wound. R1's hospital general surgery consult note dated 3/21/26, identified R1 had been admitted for management of an unstageable pressure ulcer. R1's wound in the sacral area was malodorous and had necrotic eschar with surrounding induration and erythema. R1's wound will need to be surgically debrided and would require multiple return trips to the operating room, dressing changes versus wound	20900		05/01/2026

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20900	Continued from page 25 VAC placement. The operative note report dated 3/21/26, identified R1 had a debridement and irrigation of ulcer to the ischium/sacrum. Findings included necrotic fat with pockets of foul-smelling purulence, R1 had an excisional debridement of sacral wound down to healthy bleeding tissue that measured 11.5 cm x 9.5 cm x 3.0 cm. Pale muscle fibers at the base of the wound were left. R1's infectious disease hospital note dated 3/24/26, identified R1 had been admitted due to a necrotic sacral wound that was debrided on 3/21/26 with culture that grew Proteus, Staphylococcus epidermidis, and Enterococcus. Plan to treat R1 for 2 weeks using broad spectrum antibiotics while in hospital and switching to oral antibiotics. During an interview on 3/25/26 at 2:55 p.m., nursing assistant (NA)-B stated she had not been aware R1 was supposed to be on a gel mattress and relies on looking at the resident's care plan to identify if they were on a special mattress. NA-B indicated she was unaware of R1's current care plan that directed no bedpan and to use commode at bedside. NA-B stated she had heard R1 had fallen asleep on a bedpan and that was the reason her bottom had gotten worse but was not aware when or who left R1 on a bedpan for an extended period of time. During an interview on 3/24/26 at 3:57 p.m., NA-D stated when she worked with R1 she would sometimes fall asleep on the bedpan and forget to ask for staff to take her off, however, NA-D stated staff should be aware if they placed a resident on a bedpan to ensure to take them off in a timely manner to prevent a sore from developing. NA-D had not heard R1 was not supposed to use the bedpan until after her sore had already worsened. During an interview on 3/24/26 at 3:44 p.m., NA-E stated he was not aware of which residents were at risk for skin breakdown, because his paper care guide did not identify those residents were on a repositioning program. NA-E stated he had not repositioned any resident since he came on shift at 6:00 a.m. NA-E explained he had not received any recent education on pressure ulcer prevention and if he had a resident with a new open area on a resident's skin he would make sure to clean the area, apply a barrier cream, and then tell the nurse next time he saw them. During an interview on 3/25/26 at 4:11 p.m., DON stated she had not been aware that R1's gel mattress had not been moved to her new bed on	20900		05/01/2026

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20900	Continued from page 26 3/4/26 until she assessed R1’s wound on 3/17/26 and identified R1’s wound had deteriorated. DON identified R1 should have had an air mattress put in place on her readmission on 2/24/26 due to spending more time in bed than she had before. DON stated the IDT team had reviewed R1’s coccyx pressure ulcer on 3/5/26 and 3/10/26, however, had not amended R1’s pressure reduction intervention to mitigate the risk of her pressure ulcer from worsening. DON explained she had been informed prior to the 3/10/26 IDT meeting R1 had been left on a bedpan for an undetermined amount of time, however, had not made any changes to her not using the bedpan until R1’s buttocks pressure ulcer worsened on 3/17/26. DON confirmed she had completed the wound assessment of R1’s coccyx wound on 3/17/26 and initially identified her ulcer as a “Kennedy Ulcer/End of Life Ulcer and then changed her ulcer to a stage 4 pressure ulcer. DON stated R1’s ulcer at the time of the assessment had been incorrectly identified as a stage 4 pressure ulcer when it should have been identified as an unstageable pressure ulcer. DON believe the root cause of R1’s getting a pressure ulcer was due to being left on the bedpan for an extended period of time and not have a gel mattress on her bed since 3/4/26. During an interview on 3/26/26 at 4:07 p.m., physician assistant (PA) stated she had been informed via SBAR to see if she was available to assess R1’s worsening buttocks wound in person on 3/19/26, however, there was not physician available to assess R1’s wound in person, so she gave recommendation for monitoring in the facility until her wound could be assessed on 3/20/26. PA stated she was aware of R1’s pressure ulcer and had been informed by the NP that the likely cause was due to R1 sitting on a bedpan for an undetermined time. PA stated her expectation for the facility was to put pressure relieving measures in place immediately to prevent a pressure ulcer and/or to avoid deterioration of an existing pressure ulcer. During a return phone call on 4/1/25 at 11:36 a.m., NP stated when he had assessed R1’s wound on 3/20/26 it appeared to be infected and had a large amount of purulent drainage and had foul odor and proceeded to send R1 to the ED for further evaluation of her wound. NP stated she had been informed at an earlier time that R1 had been left on the bedpan for an unknown amount of time and this likely caused the unstageable pressure ulcer. NP stated R1’s toileting plan should have been changed as soon as it was identified she had been	20900		05/01/2026

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20900	Continued from page 27 sitting on the bedpan for a long time and that she had not been informed R1's gel mattress had not been in place on her bed since 3/4/26. NP explained that by R1 not having her gel mattress in place could have likely caused R1's buttocks wound to deteriorate, and her pressure ulcer could have been avoided if all of the interventions had been in place. During an interview on 3/26/26 at 2:12 p.m., medical director (MD) stated it is his expectation for the facility to ensure all residents who are at risk for pressure ulcers have interventions put in place immediately to mitigate the risk of developing a pressure ulcer. If the resident develops a pressure ulcer the treatment/interventions need to be continually evaluated to ensure the pressure ulcer does not deteriorate. R1 not having a gel air mattress, by not altering pressure reducing interventions could have caused deterioration in her pressure ulcer thus making the pressure ulcer avoidable. During an interview on 3/24/26 at 2:29 p.m., administrator stated during the facility investigation of R1's worsened pressure ulcer that occurred on 3/17/26, it had been discovered that on 3/4/26 when R1 was transferred to a different room her gel mattress had not been applied to R1's new bed following the room change. Administrator further explained that on 3/17/26 the facility implemented a room move checklist to ensure future resident room changes that occur will ensure all pressure relieving interventions were in place at the time of the move. Administrator further explained the facility also reviewed all residents that utilized a specialty pressure reducing mattress and added an order in the treatment record to ensure the mattress was in place and functioning properly, education was provided to all nursing staff on pressure ulcer care/prevention/interventions, change of condition, and notification of physician along with a knowledge quiz on each area trained on. Despite education provided to staff according to the administrator on 3/17/26, non-compliance with pressure ulcer assessments and implementation of the care plan was identified for R4 and R5. R4 R4's Diagnoses report dated 3/27/26, identified diagnoses of diabetes and chronic kidney disease.	20900		05/01/2026

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20900	Continued from page 28 R4's admission MDS dated 3/7/26, identified R4 had intact cognition, no behaviors, no rejection of care, used a walker, used a wheelchair, needed partial or moderate assistance with taking off footwear, independent with rolling left and right in bed, partial of moderate assistance for transfers, needed supervision or touching assistance for ambulation, was at risk for developing pressure ulcers, had no unhealed pressure ulcers, no arterial or venous ulcers, had a pressure reducing device for chair and bed, did not receive any application of dressings or ointments to feet. R4's Nursing Data Collection: Admission/Readmission dated 3/3/26, identified R4 did not have any wound present. R4 had a pressure reducing mattress in place. R4's skin focus care plan initiated 3/3/26, did not identify a problem with skin. Goal of not to show complications in skin integrity. Intervention dated 3/3/26 as follows: -Inspect skin daily during care, nursing assistant to report any concerns to nurse. R4's Braden Scale for Predicating Pressure Ulcer Risk Evaluation dated 3/3/26, identified R4 was low risk for developing pressure ulcers. R4's Nursing Weekly Skin Check dated 3/7/26, indicated R4 had no skin issues. R4's progress note dated 3/10/26 at 5:40 a.m., identified R4 had a blister to left heel that measured 2.5 cm x 3.0 cm with no current treatment. New intervention of blue heel boots placed on R4. R4's record did not identify any other wound characteristics. R4's progress note dated 3/10/26 at 11:21 a.m., identified R4 had a new blister on his left heel that was identified on 3/9/26. Foam boots applied to support healing and reduce pressure. R1's record did not identify any documentation of left heel issue on 3/9/26. R4's progress note dated 3/10/26, identified SBAR sent to physician for blister on left heel. R4's physician order dated 3/10/26, included an order for left heel to cleanse with normal saline, apply foam dressing, change daily and as needed if	20900		05/01/2026

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20900	Continued from page 29 soiled or dislodged and heel protectors while in bed every shift. R4's Wound Assessment dated 3/12/26 (completed two days after identification of blister), identified R4 had a stage 1 pressure ulcer on left heel that measured 3.37 cm x 3.42 cm, with continuous aching pain, redness noted around the surrounding skin. R4's progress note dated 3/12/26, identified a Braden Scale for Predicting Pressure Ulcers completed with no sensory impairment, rarely moist, walks occasionally, had no limitations, able to make major and frequent changes in position, adequate nutrition, and had a potential problem with friction/shear, and identified as a low risk for developing pressure ulcers. R4's Nurse Practitioner note dated 3/13/26, identified R4 had a deep tissue injury to left heel measuring 2.5 cm x 3.5 cm intact fluid filled blister with no evidence of infection and to continue plan of care. R4's Nursing Weekly Skin Check dated 3/14/26, identified R4 had an "other" wound on left heel. The weekly skin check did not identify any measurements or description of the wound. R4's skin focus care plan problem revised on 3/16/26 (6 days after the identification of the blister) that R4 at risk for skin injury related to pressure due to decreased mobility. Intervention added 3/16/26 of pressure reducing device for chair and bed. R4's Wound Assessment dated 3/21/26, identified a Stage 2 pressure ulcer on his left heel. Measurements of 2.56 cm x 2.4 cm, intermittent sharp pain, with intact unbroken surrounding skin. The assessment did not include any other wound characteristics. R4's skin focus care plan revised on 3/21/26 to offer offloading every 2-3 hours and as needed. R4's skin focus care plan revised again 3/24/26 to turn and reposition every 2 hours and as needed. During an observation and interview on 3/25/26 at 10:58 a.m., R4 was lying on his bed with shoes on and his heels resting on his bed. R4 did not have heel protectors on while in bed. NA-C then entered R4's room and took his meal order, however, did not ask R4 if she could put R4's heel protectors on his feet. NA-C stated R4 had a pressure ulcer on his left heel and was supposed to have his heel protectors on when in bed but had not noticed that	20900		05/01/2026

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20900	Continued from page 30 they were not on when he was lying in his bed. NA-C then went back into R4's room and applied both heel protectors on his feet. During an interview on 3/26/26 at 10:18 a.m., NA-A stated R4 received an air mattress today due to a pressure ulcer on his left heel. R4 was supposed to be wearing blue boots on his bilateral heels when in bed, however, he would self-transfer at times and lay in his bed without his blue boots. NA-A stated R4 should have had the air mattress as soon as the heel pressure ulcer was identified. NA-A could not articulate on how to identify if a resident was identified as high risk for pressure ulcers and relied on being informed at report from the nurse if they were supposed to be on a turning and repositioning schedule. During an observation and interview on 3/27/26 at 9:11a.m., R4 was seated in his recliner with shoes on. Certified Wound Nurse Practitioner (CNP-WOC) removed R4 left shoe and described R4's wound as a reabsorbed blister on the back of R4's left heel. CNP-WOC stated that the wound was from pressure from the bed or from shoe. R4 stated a while ago he fell asleep "hard" in bed one night and woke up with terrible pain in his left heel and since then he put on these special "boots" in bed. R4, stated he has numbness in his feet at times and that may be why he did not feel it hurting. CNP-WOC recommended R4 not wear shoes and use gripper socks until the wound was completely healed. R4's Wound Nurse Practitioner note dated 3/27/26, identified R4 had been seen for a blister on his left heel. Recommendations to wear gripper socks when up and blue heel boots on when in bed. Continue order to cleanse with normal saline, apply skin prep to entire wound, allow to dry, apply foam dressing, change daily and as needed if soiled. R5 R5's Diagnosis report dated 3/27/26, identified diagnoses of fracture of right femur, heart failure, cancer of the prostate, diabetes, and end stage renal disease. R5's Braden Scale -for Predicting Pressure Ulcer Risk Evaluation dated 1/20/26 identified R5 was low risk for developing pressure ulcers. R5's ADL focus care plan dated 1/20/26, identified R5 triggered in ADLs because had preferences and other items of	20900		05/01/2026

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20900	Continued from page 31 need. Goal to gain endurance with transfers and ambulation. Interventions as follows: -Extensive assistance for bed mobility. R5's Skin focus care plan dated 1/20/26 (revised on 1/30/26), identified R5 was at risk for pressure injury. Goal to remain free from pressure injuries or skin breakdown. Interventions as follows: -Inspect skin daily with cares and nursing assistant to report any concerns to the nurse. (dated 1/20/26). -Pressure reducing cushion for wheelchair. (dated 1/20/26) R5's hospital discharge summary dated 3/10/26, identified R5 had been hospitalized 2/27/26 through 3/10/26 for a repair of fracture of the right hip. R5's Braden Scale-for Predicting Pressure Ulcer Risk Evaluation dated 3/10/26, identified R5 was moderate risk for pressure ulcers due to no impairment with sensory, very moist skin, being chairfast, being very limited with mobility, adequate nutrition, and problem with friction/shear. R5's skin focus care plan interventions revised on 3/10/26 to turn and reposition every 2-3 hours while sleeping. R5's Nursing Weekly Skin Check dated 3/10/26, identified R5 had no skin issues except for edema in bilateral lower extremities. R5's physician orders identified the following: -Elevate heels when in bed. (dated 3/10/26) -Reposition every 2 hours. (dated 3/22/26) R5's significant Change MDS dated 3/16/26, identified R5 had intact cognition, no behaviors, no rejection of care, used a wheelchair, dependent for toileting hygiene, substantial/maximum assistance for roll left and right in bed, dependent for transfers, at risk for developing pressure ulcers, had no unhealed pressure ulcers/injuries, no venous/arterial ulcers, had pressure reducing device in chair, no pressure reducing device in bed, and received dialysis.	20900		05/01/2026

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20900	Continued from page 32 R5's Nursing Weekly Skin Check dated 3/19/26, identified a pressure ulcer on coccyx measuring 2.0 cm x 1.0 cm, no depth nor staging, with skin breakdown on the coccyx, area cleaned and applied zinc and covered with foam dressing. R5's Skin Issue Wound Assessment dated 3/19/26, identified a stage 2 pressure ulcer on coccyx that measured 1.2 cm x 1.67 cm, with no depth identified, with 100% granulation, no drainage, with erythema/dry skin noted in surrounding tissue. R5's physician orders identified an order dated 3/22/26 for Mepilex dressing to stage 2 pressure ulcer on buttocks to change every 72 hours and as needed until healed. R5's physician orders dated 3/22/26, identified an order for an air mattress to check every shift for proper placement and functioning. During an interview on 3/27/26 at 9:42 a.m., registered nurse (RN)-A stated R5 had been complaining of pain in his left heel since yesterday, however, RN-A had not completed a skin assessment on R5's heel to check for any pressure concerns. During an observation and interview on 3/27/26 at 9:03 a.m., R5 was seated in his chair, DON and NA-F then used a stand aid to place R5 in bed. R5 informed DON that his left heel hurt "really bad". R5 was then placed in bed and continued to state his left heel hurt. DON removed R5's brief and an open area was noted on his left buttocks with no dressing over the wound that was approximately 2.0 cm x 2.0 cm in size, with the top layer of skin off the wound, red center, and maceration noted around the edges of the wound. DON described the wound as a stage 2 pressure ulcer. CNP-WOC identified wound as a stage 2 pressure ulcer and needed to be covered at all times. R5 complained of severe pain in his left heel, CNP-WOC assessed R5's left heel and stated heel was "boggy" and had a deep tissue injury approximately 0.5 cm x 0.5 cm. RN-B entered R5's room and stated she had been informed by the night shift nurse that R5's coccyx dressing change had been completed, however, RN-B was not aware R5 did not have a dressing on his buttocks wound. RN-B explained that she had been informed that R5 had refused to wear his blue boots last night but was unsure of the rationale for not wearing the boots. During an interview on 3/27/26 at 10:11 a.m., RN-C	20900		05/01/2026

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20900	Continued from page 33 stated she had worked the night shift on 3/27/26 and during that time R5 had refused to wear his heel protectors during the night shift and RN-C explained she had provided R5 education of the risks of not wearing the heel protectors, however, R5 continued to refuse. RN-C stated she had applied an as needed coccyx dressing to R5 at the beginning of her shift, however, had not documented in R5's record when she had applied a new dressing. RN-C stated R5 had not complained of pain in his left heel during the night shift, however, RN-C had not assessed R5's heels nor asked the reason why R5 did not want to wear the heel protectors. R5's Wound Nurse Practitioner note dated 3/27/26, identified R5 was seen for a stage 2 pressure ulcer on coccyx. R5 complained of pain in left heel and noted a deep tissue injury to the area. New orders to buttocks ulcer to cleanse with wound cleanser, pat dry, apply foam dressing every 72 hours and change as needed, apply barrier cream to wound; left heel deep tissue injury orders to cleanse with normal saline, pat dry, cover with betadine, complete daily, apply blue boots on when in bed. During a return phone call on 4/1/26 at 11:36 a.m., NP stated when R5 was readmitted from the hospital on 3/10/26 for a hip fracture, his mobility status changed and should have had an air mattress put in place on readmission to mitigate the risk of developing a pressure ulcer and that R5's stage 2 pressure ulcer he developed was avoidable. During an interview on 3/25/26 at 3:42 p.m., licensed practical nurse (LPN)-B was not able to articulate how to complete and assessment of a new skin issue of redness (such as blanchable versus non-blanchable redness) or what type of interventions she would put in place for an identified new skin concern. LPN-B explained if staff had brought a concern of a purple area on a heel this would indicate that the resident may have fallen in which had caused a "bruise" and would not be related to pressure. LPN-C could not articulate what a deep tissue injury was or how they develop on bony prominences. During an interview on 3/26/26 at 2:01 p.m., DON stated she had not received any training on being able to complete a comprehensive wound assessments and sometime she did not feel comfortable identifying specific wound staging and relies on the certified wound nurse to assist with making wound type of determinations.	20900		05/01/2026

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20900	Continued from page 34 Review of the facility's Pressure Injury Prevention Policy dated 1/21/26, identified the facility will maintain a systematic, interdisciplinary approach to pressure injury prevention and management. All residents will be assessed for risk upon admission and as clinically indicated, and those identified as at risk will receive individualized, evidence-based interventions to prevent the development of pressure injuries. The facility will monitor the effectiveness of these interventions, promptly address changes in condition, and revise care plans as necessary to ensure optimal outcomes and compliance with professional standards of practice. Assessment of Pressure Injury Risk: -Licensed nurses will conduct a pressure injury risk assessment and full body skin examination on all residents. -If a new wound is identified, documentation, notification, and follow-up will be conducted in alignment with established procedures. -Risk assessment will also be conducted after a significant change in condition that may affect pressure injury risk (e.g., decline in mobility, change in nutritional status, new incontinence, prolonged acute illness). -A standardized pressure injury risk assessment will be conducted, using a validated risk assessment tool or scale. The Braden Scale for Predicting Pressure Injury Risk (Braden Scale) has been designated as the standardized tool. -The Braden Scale will be used in conjunction with other risk factors not captured by the risk assessment tools, including, but not limited to: Ongoing Evaluation of Resident Skin Condition: -Licensed nurses will conduct a full body skin evaluation on all residents on at least a weekly basis. -Nursing assistants will observe skin integrity during routine care activities such as bathing, toileting, repositioning, and dressing changes. Any	20900		05/01/2026

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20900	Continued from page 35 redness, bruising, discoloration, or other skin concerns will be reported to the licensed nurse immediately and documented in accordance with established procedures. Interventions for Prevention of Pressure Injuries: -After completing a thorough evaluation, the interdisciplinary team will develop a relevant care plan that includes measurable goals for the prevention of pressure injuries with appropriate evidence-based interventions for all residents assessed as at-risk for developing pressure injuries. -Interventions will be based on specific factors identified in the risk assessment and the full body skin evaluation (e.g., moisture management, impaired mobility, nutritional deficit). -Basic or routine care interventions may include, but are not limited to: -Redistribution of pressure (e.g., repositioning, protecting and/or offloading heels, etc.); minimizing exposure to moisture and keeping the skin clean; providing appropriate pressure-redistributing support surfaces; providing non-irritating surfaces; and maintaining or improving nutrition and hydration status. -Residents identified as at-risk for pressure injury development will be referred to the dietician for evaluation of nutritional and hydration status. Nutritional interventions (e.g., supplements, fortified meals, hydration plans) will be incorporated into the resident's care plan as appropriate. -Interventions will be implemented in accordance with provider orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them. -In the absence of prevention orders, the licensed nurse will utilize professional judgment in accordance with pressure injury prevention guidelines to provide care and will notify the provider to obtain orders. -The selection of prevention devices and support	20900		05/01/2026

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20900	Continued from page 36 surfaces (e.g., heel floatation devices, cushions, mattresses) will be based on individual risk factors, mobility, weight, and skin condition. Prevention devices and support surfaces will be utilized in accordance with the manufacturer’s recommendations and evaluated regularly for effectiveness and condition. -The goals and preferences of the residents and/or their representatives will be included in the care plan. Preventative interventions and risk factors will be communicated to all staff involved in the residents’ care, including nursing assistants, therapy staff, and dietary services to ensure coordinated implementation of the care plan. -Compliance with interventions will be documented in the medical record in accordance with established procedures. Ongoing Monitoring: -The effectiveness of interventions will be monitored through ongoing assessment of the resident. -A Focused Incident Review will be performed on each pressure injury that develops in the facility. Findings will be reported in the Quality Assurance and Performance Improvement (QAPI) meetings. -The effectiveness of current preventative modalities and processes will be discussed in accordance with the QAPI Committee schedule, and as needed when actual or potential problems are identified. -Pressure injury incidence and prevalence data will be trended and reviewed routinely as part of the facility’s QAPI program to identify systemic opportunities for improvement. Modification of Interventions: -Any changes to the facility’s pressure injury prevention and management processes will be communicated to relevant staff in a timely manner. -Resident care plan interventions will be modified as needed. Considerations for needed	20900		05/01/2026

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20900	Continued from page 37 modifications include, but are not limited to: Changes in the resident's degree of risk for developing a pressure injury; New onset or recurrent pressure injury development; Lack of progression toward healing; Resident non-compliance, and/or changes in the resident's goals and preferences in accordance with their rights (e.g., end-of-life care); -Resident or representative decisions to decline or modify interventions will be respected and documented. Staff will educate the residents and/or representative regarding potential risks and alternatives when care is declined. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20900		05/01/2026
21390	Infection Control CFR(s): MN Rule 4658.0800 Subp. 4 A-I Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents;	21390	Date of Alleged Compliance: 5/01/2026	05/01/2026

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21390	Continued from page 38 D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper handwashing/hand hygiene was implemented for 1 of 3 residents (R3) observed during wound care. In addition, the facility failed to ensure enhanced barrier precautions (EBP) were utilized during a transfer for 1 of 3 residents (R3). Findings include: R3’s face sheet dated 3/27/26, identified diagnoses of diabetes, non-pressure chronic ulcer of right lower leg, and kidney transplant. R3’s quarterly Minimum Data Set (MDS) dated 1/14/26, identified R3 had intact cognition, no behaviors, no rejection of care, needed partial/moderate assistance for transfers, was occasionally incontinent of bowel, has no pressure ulcers, had no venous or arterial ulcers, had no moisture associated skin damage, had an application of non-surgical dressing other than feet, application of ointment other than feet and received dialysis. R3’s care plan dated 7/24/25, identified R3 needed EBP. Goal that staff will maintain enhanced barrier precautions when performing high contact resident care activities. Interventions as follows:	21390		05/01/2026

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21390	Continued from page 39 -Don (apply) gown and gloves during wound care. (dated 7/24/25) -Don gown and gloves for the following high-contact resident care activities (dressing, bathing/showering, transferring, providing hygiene, changing linens, changing brief or assisting with toileting, catheter care.) (dated 7/24/25) R3's Wound Assessment dated 3/19/26, identified R4 had an open lesion on his right gluteus (group of muscles in the buttocks) that measured 0.5 centimeters (cm) x 0.74 cm. During an observation on 3/26/26 at 3:20 p.m., R3' room had a sign near the door that indicated R3 needed EBP for high contact care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing brief, or assisting with toileting, catheter care. During an interview on 3/26/26 at 3:22 p.m., nursing assistant (NA)-G stated R3 needed EBP (gown and gloves) for high contact care activities because he had a wound on his right buttocks. During an observation and interview on 3/26/26 at 4:39 p.m., director of nursing (DON) was outside of R3's room, performed hand hygiene and applied a gown prior to entering R3's room. DON then entered R3's room where R3 was lying in bed. R3 was informed that a physician wanted to assess R3's right gluteal wound via a telehealth (video visit) in which R3 agreed. DON then placed the computer on R3's bed, went into the bathroom and applied gloves, without performing hand hygiene. DON then removed R3's brief and proceeded to remove a foam dressing that was near R3's right gluteal area. R3's foam dressing had stool on the left corner of the dressing. DON then placed the dressing in the trash, removed gloves, then applied new gloves, without performing hand hygiene prior to application of the new gloves. Surveyor intervened and asked DON when should hand hygiene/hand washing be done in which the DON stated hand hygiene should be done when hands/gloves are visibly soiled, before and after removing/applying gloves. DON confirmed she had not performed hand hygiene each time she had removed/applied gloves. DON then removed her gloves, performed hand hygiene, and applied new gloves. DON then completed the wound dressing change and performed hand hygiene appropriately. During an observation and interview on 3/27/26 at 7:31 a.m., R3 was seated in his chair in his room. An unknown nursing assistant (NA) who had a gown	21390		05/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29822	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/27/2026

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21390	Continued from page 40 and gloves on then entered R3's room with a sit-to-stand mechanical lift. DON then applied the lift harness under R3's arms, cinched the waist strap while encountering R3's clothes in the process. DON then hooked up the harness to the machine, moved R3's left hand toward the handle on the lift with ungloved hands. DON and NA then transferred R3 to the bed when DON then pulled R3's pants down. R3 was then removed the harness while touching R3's clothes. Certified Nurse Practitioner Wound Nurse (CNP-WOC) then removed the dressing on R3's right gluteal area with gown and gloves on and assessed R3's wound and applied a new dressing. Hand hygiene was performed during the dressing change. DON then sat up R3 on the edge of the bed, touching his upper body with gown but no gloves, applied the lift harness under his arms and around R3's waist with a gown, but no gloves. R3 was then hooked up to the lift and as R3 stood, DON pulled up R3's pants and adjusted R3's shirt. Upon exiting R3's room, DON stated EBP was only needed if performing catheter or wound care and was not needed during transfers. DON then read the EBP sign that was outside of R3's room and identified that EBP was needed during any high contact resident care activities including transfers. Review of the facility's Enhanced Barrier Precautions Policy undated, identified It is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multidrug-resistant organism (MDRO) such as a resident with wounds, indwelling medical devices or residents with "infection or colonization with an MDRO". The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of MDROs to employees' hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids. High-Contact Resident Care Activities include: Dressing Bathing/showering Transferring Providing hygiene Changing linens	21390		05/01/2026

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21390	Continued from page 41 Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube. Wound care: any skin opening requiring a dressing.” Procedure Standard Precautions should be applied to all residents at all times. Transmission-based precautions should be applied to all residents when standard precautions alone do not prevent pathogen transmission. Enhanced Barrier Precautions are to be implemented in addition to Standard Precautions when other Transmission-Based precautions do not apply, when facility identifies any resident with: MDRO infection or colonization when Contact Precautions do not otherwise apply. If resident is infected or colonized with any MDRO and has secretions or excretions that are unable to be covered or contained, the resident should be placed on contact precautions. Wounds or skin openings such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers Shorter-lasting wounds such as skin breaks or skin tears covered with an adhesive bandage would not need Enhanced Barrier Precautions Any indwelling medical device, regardless of MDRO colonization status, for example: Central lines Peripheral intravenous line is not considered an indwelling medical device for the purposes of EBP.”2 Urinary catheters	21390		05/01/2026

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21390	Continued from page 42 Feeding tubes Tracheostomy/ventilator Personal Protective equipment is required for all staff providing high-contact resident care activities to include: Gown and gloves with: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care:any skin opening requiring a dressing.” SUGGESTED METHOD OF CORRECTION: The Infection Control Preventionist (ICP) or designee could review facility policies/procedures regarding appropriate infection control technique during dressing changes and usage of enhanced barrier precautions. The ICP or designee could provide staff education regarding the policies and educate staff on appropriate IC technique while performing dressing changes and enhanced barrier precautions. The ICP or designee should complete timely audits to ensure policies are being followed to ensure on-going competence. The ICP, or designee should take education verifications and the audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		05/01/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Restorative Care Center	**501 EIGHTH AVENUE SOUTHEAST , ROCHESTER, Minnesota, 55904**

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F0000	INITIAL COMMENTS On 4/8/26 to 4/13/26, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. The IJ at F689 began on 3/26/26, when the facility failed to implement and monitor known aspiration precautions for residents with dysphagia, including ensuring correct diet texture, prescribed liquid consistency, supervision during meals, and safe meal positioning. This resulted in an Immediate Jeopardy (IJ) for R1. The following complaints were reviewed: H51841114C (MN 254988007, 254996007, 255002009, 255090002) with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		04/29/2026
F0803 SS = J	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;	F0803	F803 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: (R1) was able to clear airway successfully without intervention. (R1) was transferred to hospital for evaluation on 3/26/2026 and returned to facility on	05/08/2026

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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F0803 SS = J	Continued from page 1 §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to implement and monitor known aspiration precautions for residents with dysphagia, including ensuring correct diet texture, prescribed liquid consistency, supervision during meals, and safe meal positioning. This resulted in an Immediate Jeopardy (IJ) for R1 when the facility failed to ensure these requirements were consistently communicated to and followed by nursing and dietary staff for R1 which resulted in R1's hospitalization for diagnoses of pneumonitis due to inhalation of food and vomit and following hospitalization, the facility failed to follow R1's prescribed diet putting R1 at risk for additional choking and or aspiration events. Additionally, the facility failed to ensure the correct liquid consistency was provided according to the dietary order and failed to comprehensively assess and monitor R6 following a coughing episode for signs and symptoms of aspiration, placing R6 at risk for aspiration-related complications. The IJ began on 3/26/26, when R1 with known dysphagia and aspiration precautions, was permitted to eat unsupervised in bed and experienced a suspected aspiration event requiring hospitalization. The facility failed to implement corrective action which resulted in incorrect diet type served to R1 on 4/8/26 and 4/9/26. The Administrator and director	F0803	Continued from page 1 3/30/2026 with no changes to treatment plan. (R1) hospital chest x-ray and lab work were negative for any indication or diagnosis of Pneumonitis OR any type of aspiration pneumonia, OR any other infection or harm. There were NO changes to treatment plan OR harm to resident from this incident per hospital records. Help ticket was placed by the dietary manager to resolve the issue of tray tracker inconsistencies with tray tickets on review there were no inconsistencies with tray tickets (R1) family frequently brings in food and liquids in direct contrast with his diet order. Education and risk vs benefits was provided to the family and resident on dietary restrictions. (R1) care plan and Kardex updated to include diet order and supervision requirements. (R1) refuses to leave room for meals, staff member will be present with resident during meals. (R1) family educated supervision requirements and informed that is a staff member is not available to sit with resident they would have to wait to provide any foods or fluids to resident until staff member is available. Education was provided to speech therapist on ensuring written communication is provided to licensed clinical staff to ensure coordination of care with diet texture and supervision requirements. (R1) discharged home with family with no issues How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken: All residents on a mechanically altered diet have the potential to be affected. An audit was completed of tray tickets to ensure they match the dietary orders by the dietary manager on 4/10/2026	05/08/2026

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F0803 SS = J	Continued from page 2 of nursing (DON) were notified of the IJ on 4/10/26 at 2:26 p.m. The IJ was removed on 4/11/26, but non-compliance remained at the lower scope and severity level D, which indicated no actual harm, with the potential for more than minimal harm that is not immediate jeopardy Findings include Mechanical soft diet: texture-modified diet designed for people who have difficulty chewing or swallowing, such as those with dysphagia (difficulty swallowing) or missing teeth. Mechanical soft diet allows foods that are soft, moist, and easy to manipulate in the mouth. Foods are typically cut into small pieces no larger than ¼ to ½ inch or blended to a soft consistency. Meats, vegetables and fruits can be chopped, minced, or ground. Foods should be moistened with gravies, sauces, milk, or cooking liquids to make them easier to swallow. Breads and cereal can be softened with milk, yogurt, or sauces to create a slurry-like consistency. Mildly thick liquids: are slightly thicker than water, designed to flow more slowly for safer swallowing, and often used for people with dysphagia. This reduces the risk of choking or aspiration for people with swallowing difficulties. Generally, one tablespoon of powdered thickener to four ounces of liquid stirred vigorously will create the desired consistency. R1's face sheet dated 4/9/26, identified diagnoses of stroke, dysphasia, and hemiplegia (complete paralysis on one side of body) and hemiparesis (weakness on one side of body) affecting left side of body. R1's hospital After Visit Summary dated 2/23/26, identified R1 admitted to the hospital due to stroke. R1 was discharged to facility with a diet of mildly thick liquids and mechanical soft food. Safety precautions included raised head of bed, awake/alert, slow rate, small bites/sips, and frequent oral care. Medication was recommended whole with puree. Speech language pathologist (SLP) to continue to follow for cognitive-communication and dysphagia management. During an interview on 4/8/26 at 10:59 a.m., RN-B stated prior to a resident admitting to the facility, the nurse would receive a phone call from the nurse at the hospital that informed the facility staff which diet the resident required. The facility admission packet included a form the admitting nurse would fill out that was then passed out to the nursing assistants	F0803	Continued from page 2 Progress notes for past 30 days were reviewed to ensure there were no other "choking" incidents documented on 4/6/2026 by DON with no other incidents Residents receiving mechanically altered diets received education by DON/Designee on importance of being out of bed and in dining room for meals any residents requiring supervision refusing to eat in the dining room will be provided supervision in their room. Audit was completed by therapy on all residents to ensure dietary requirements and supervision requirements of residents was communicated to nursing. Audit was completed by MDS to ensure Care Plans and Kardexes were updated to include diet orders and supervision needs of the resident Ad Hoc resident council was held on 4/10/2026 by Activity Director to educate residents on need on for residents to have mechanically altered diets to be out of bed and in dining room for meals What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur; and: Education with clinical staff on the mechanically altered diet policy, diet consistency, verifying diet accuracy prior to serving meals, supervision during meals, change in condition assessment and SBAR by the DON/Designee on 4/10/2026 with any staff receiving education by 4/11/2026 not being allowed to work until receiving education Huddles will be held by the floor nurse at start of shift to pass along any changes in resident condition or orders. Speech communication will include verification of what specific supervision is needed for those with altered diets and will be verbally given to nursing staff, written on the Therapy Communication to Nursing form and updated/uploaded into residents	05/08/2026

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F0803 SS = J	Continued from page 3 (NA) and nurses. If a resident required supervision to eat, the resident would be brought to the dining room and either the nurse or NAs would supervise them. An aspiration event would include choking which dictated the resident was unable to eat without supervision. R1's admission Minimum Data Set (MDS) dated 3/7/26, identified R1 had no cognition issues. R1 had a mechanically altered diet, held food in mouth/cheeks or residual food in mouth after meals, and was edentulous (lacked teeth). R1 required partial/moderate assistance to eat. R1's care plan dated 2/23/26, identified R1 had diagnoses of dysphasia, aphasia (complete inability or refusal to swallow), however did not identify R1's risk for aspiration/choking. The care plan directed that R1 required contact/limited assistance of one for eating. The care plan revised on 2/26/26 directed staff to provide R1 assistance with drinking and to alternate small bites and sips, and use a teaspoon for eating. Although the care plan directed staff assistance, the care plan did not address level of supervision and appropriate positioning while eating. The care plan revised on 4/2/26 directed staff to provide R1 diet as ordered. R1's physician order dated 2/23/26, identified R1's diet was mechanical soft texture and mildly thick consistency. R1's Montreal Cognitive Assessment (MoCA) (test used to determine cognitive impairment) dated 2/25/26, indicated R1 had significant cognitive deficits. The assessment also included R1 was unable to complete full cognitive screening tool due to repeatedly expressed desire to urinate and defecate. Will continue to assess as R1 is able to participate. R1's progress note dated 2/28/26, identified R1 was approached several times before breakfast and lunch to get up and refused. R1 ate both meals in bed. R1's progress note dated 3/1/26, identified Staff offered to get R1 out of bed for breakfast and lunch. R1 stated "no shower, no get up. I eat here." R1's care plan 3/1/26, staff check mouth after meal for pocketed food and debris, report to nurse, provide oral care to remove debris. R1's Comprehensive Nutrition Assessment dated 3/2/26, identified R1 was on a regular diet with mechanical soft texture and mildly thick consistency	F0803	Continued from page 3 Medical Record, Care Plan, and staff tasks to complete. All written speech communication forms will be reviewed daily Monday – Friday as part of the clinical morning meeting process to ensure Orders, Care Plan, Kardex have been updated to reflect the appropriate diet and supervision requirements of the residents. Any communication slips generated over the weekend will be reviewed on Monday. A nurse will be present in dining room for meals to ensure appropriate diets are served and monitor residents for choking and to assist in providing general supervision of residents dining in the dining room. Residents requiring direct supervision during meals and preferring to eat in their room will have a staff member present to provide direct supervision during meals Education was initiated by dietary manager with dietary staff on 4/10/2026 on diet consistencies and serving the appropriate diet per tray ticket with any staff not receiving education by 4/11/2026 not being allowed to work until receiving education Random audit which will include observations on all three meals will be completed on 6 trays of high risk residents daily x 2 weeks to ensure diet matches the dietary order and appropriate supervision is provided per the care plan, 5 trays of high risk residents to 5/week x 2 weeks to ensure diet matches the dietary order and appropriate supervision is provided per the care plan, then 5 trays of high risk residents 3/wk x 4 weeks to ensure diet matches the dietary order and appropriate supervision is provided per the care plan, then 6 trays of high risk residents will be audited weekly x 4 weeks to ensure diet matches the dietary order and appropriate supervision is provided per the care plan or until substantial compliance is maintained and finding with be reviewed in QAPI Describe the Quality Assurance and Process Improvement Program that will be put into place. Ad Hoc QAPI was held on 4/10/2026 to review IJ and approve the abatement plan with the Medical Director attending via phone. Results of audits will	05/08/2026

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F0803 SS = J	Continued from page 4 for liquids. Chewing/swallowing problems: modified textures/consistencies. R1's Care Conference Summary dated 3/2/26, indicated R1 had a mechanical soft diet with thickened liquids and required variable assistance with food and fluids. R1 required set-up assistance, supervision, and CGA (contact guard assist) as needed for intake. R1's progress note dated 3/3/26, identified R1 maintains relatively good position in chair or bed most of the time but occasionally slides down. "AT RISK." (The specific risk was not documented in note.) SLP note on 3/3/26, identified family in room during session. Discussed communication cards family had been bringing R1 and practiced use of these for wants/needs/thoughts. Family had questions regarding R1's movement and sensation of arm and leg-encouraged to speak with other disciplines when visiting. R1's progress note dated 3/5/26, identified R1 ate the evening meal in bed. R1's Speech Language Pathology (SLP) Summary of Daily Skilled Services dated 3/18/26, identified R1 completed a visuospatial/executive functioning, concentration, and direction following task which he completed with overall moderate level of deficits requiring moderate and verbal cues. A second MOCA was completed on 3/19/26, with R1 scoring 6/30 with ongoing significant deficits present. MoCA scores of <10 is suggestive of severe cognitive impairment. Key areas of the MoCA examine Visuospatial and Executive Functions, Naming, Memory, and Attention. SLP Summary of Daily Skilled Services dated 3/19/26, R1's current diet changed from "mechanical soft/chopped" to "mechanical soft/ground." R1's progress note dated 3/20/26, identified SLP recommended a video swallow study to rule out aspiration and determine the most appropriate, least restrictive solid and liquid consistencies. SLP Summary of Daily Skilled Services 3/25/26, R1 had thin liquids in his room. Educated nursing staff on need for mildly thick liquids until video swallow study completed. Thickened liquid appropriately.	F0803	Continued from page 4 be reviewed at QAPI meeting monthly x 3 months or until substantial compliance is maintained Facility alleges substantial compliance on 5/8/2026	05/08/2026

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F0803 SS = J	Continued from page 5 SLP Summary of Daily Skilled Services dated 3/26/26, R1 had audible expiratory wheezing and increased work of breathing during session. Encouraged R1 to be out of bed for meals to prevent aspiration. Continue to ensure appropriate solid and liquid levels are received as thin liquids were previously given. Staff educated. Review of R1's record revealed R1's care plan was not updated to include the directive for R1 to be out of bed for meals or safe swallowing strategies. During a telephone interview on 4/9/26 at 3:45 p.m., SLP-A stated the Brief Interview for Mental Status (BIMS) (cognition test used by nursing staff to determine cognition) was not as comprehensive of an assessment as the MoCA. SLP-A had a live translator help conduct R1's MoCA and completed it on 2/26/26. SLP-A recommended staff to assist at meals and have supervision for safe swallowing as R1 had cognition and learning recall issues. SLP-A talked with staff to get R1 out of bed for meals and staff would say R1 refused. R1 did not always have appropriate liquids provided to him and that was from both the facility and family. R1 should have had supervision while he was eating and drinking to ensure he was following compensatory strategies. SLP-A could not recall if she had written specific orders for nursing staff to supervise R1, but professional standard dictated not to have R1 eat independently or in bed. On 3/26/26, SLP-A communicated to nursing staff about compensatory strategies to use with R1 during eating and drinking. During an interview on 4/9/26 at 2:09 p.m., licensed practical nurse (LPN)-A stated the therapy department had expressed many times that R1 needed to be up for meals and out of bed. R1 refused to get out of bed to eat many times. LPN-A stated she would encourage R1 to get out of bed for meals because it would be easier to swallow and better to eat if he was in a wheelchair. LPN-A was not aware of staff watching R1 when he ate in his room. LPN-A could not recall having a conversation with SLP-A on 3/26/26, regarding R1 having expiratory wheezes, getting out of bed for meals, or having supervision when he ate. During an interview on 4/9/26 at 1:49 p.m., nurse manager (NM)-A stated on 3/26/26 she had not received any communication from SLP-A that R1 should not eat in bed and needed supervision with eating and drinking. SLP-A would evaluate residents to ensure they are not at risk eating in their rooms. NM-A thought a lot of residents continued eating in their rooms post covid because they enjoy their own space. NM-A stated staff did not keep track of	F0803		05/08/2026

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F0803 SS = J	Continued from page 6 residents when they eat in their rooms. R1's progress note dated 3/26/26 at 10:42 p.m., R1 appeared to choke while eating dinner around 6:10 p.m. Registered nurse (RN)-A heard R1 cough from down the hall and saw R1 trying to spit out. R1 had the head of bed all the way up and was able to cough up phlegm but explained he still felt like something was inside his throat. Vital signs: temperature 97.5 degrees Fahrenheit, blood pressure 163/83 mmHg (millimeters of mercury), heart rate 87 bpm (beats per minute), respiration rate 22, and oxygen saturation 93% (percent) on RA (room air). R1 was sent to the hospital for further evaluation. R1's dietary ticket for dinner dated 3/26/26, included nectar thickened liquids, straws ok. Ground Philly steak for sandwich* pureed hot dog bun, sauteed peppers and onion-chop, mashed potatoes, capri vegetable blend-chop, chilled pears, and cottage cheese. Nectar thickened milk, coffee or hot tea. The ticket did not identify what the Asterix represented. During an interview on 4/8/26 at 3:04 p.m., nursing assistant (NA)-C stated R1 had trouble with swallowing and required thickened liquids and either minced & moist or pureed food. NA-C explained she worked on 3/26/26 and gave R1 his dinner tray in bed. NA-C did not remain in the room to assist or watch R1 eat his meal but R1's head of bed was all the way up. At around 6:00 p.m. NA-C saw nurses going towards R1's room. R1 stated he felt like he had something in his mouth and coughed up "a huge chunk of phlegm". NA-C stated the phlegm was about the size of a nickel. R1 was sent to the emergency department as a precaution because he choked on food. During an interview on 4/8/26 at 2:58 p.m., nursing assistant (NA)-B worked the evening of 3/26/26. NA-B stated R1's head of bed was all the way up and R1's meat was mechanical soft texture. NA-B was not on the unit when R1 choked but returned to the unit and saw NA-C and RN-A run to R1's room. During an interview on 4/8/26 at 3:14 p.m., registered nurse (RN)-A stated on 3/26/26, she was by the nurse's station when she heard R1 cough. R1's head of the bed was all the way up. R1 was spitting up a lot of whitish/yellow colored phlegm. R1 was able to talk. R1 was the only person in the room, he did not have staff supervise him while he ate. R1's food was mechanical soft hot dog and beans with thickened drinks. RN-A was unaware how it was determined R1 could eat without	F0803		05/08/2026

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F0803 SS = J	Continued from page 7 supervision. R1 spent a lot of time in his room eating by himself. R1 had refused to leave his room and would not get up to eat in his wheelchair. RN-A thought residents with a previous history of aspiration or on “super thickened” liquids would require supervision while eating but that determination was made by someone other than nurses. RN-A sent R1 to the emergency department to be evaluated for concerns of aspiration. When R1 left, he still felt like something was stuck in his throat. R1’s hospital After Visit Summary dated 3/30/26, identified R1 was admitted on 3/26/26 for pneumonitis (inflammation of the lung tissue) due to inhalation of food and vomit after a suspected aspiration event while eating at his facility. SLP was consulted for evaluation of dysphagia related to history of stroke and aspiration event. R1 had a video swallow study completed and was recommended to have a modified diet of mildly thick liquids International Dysphagia Diet Standardization Initiative (IDDSI Level 2) and soft, bite-sized solids (IDDSI Level 6), with aspiration precautions and ongoing supervision during meals. R1 was discharged back to the facility on 3/30/26. The IDDSI identified mildly thick liquids flow off spoon, sippable, pour quickly from spoon and slower than thin drinks, and mild effort is required to drink this thickness through standard bore straw. Soft and bite-sized solids were indicated as ‘bite-sized’ pieces as appropriate for size and oral processing skills, soft, tender and moist throughout but with no separate thin liquid, chewing required before swallowing, a knife was not required to cut this food, can be mashed/broken down with pressure from utensil, and can be eaten with a fork, spoon or chopsticks. During an interview on 4/8/26 at 12:23 p.m., LPN-D stated R1 used to eat in his room a lot, mostly sitting straight up in bed. At the time of the incident on 3/26/26, staff did not have to supervise R1 while he ate or drank. LPN-D stated the facility did not have an assessment that identified if a resident was able to eat independently. During an observation on 4/8/26 at 9:16 a.m., R1 was not in his room. On R1’s nightstand there were eight brown bananas, three Activia yogurts, one thickened apple juice container, an unopened can of coke, an unopened Boost, unlabeled hard candies, a muffin, and thickened water in a water pitcher. At 10:55 a.m., R1 was alone in his room in his bed with head of bed up halfway with food items on the	F0803		05/08/2026

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F0803 SS = J	Continued from page 8 nightstand. R1's physician order dated 4/1/26, identified R1's diet was mechanical soft texture, nectar thick liquids, and soft and bite size for dysphagia. R1's dietary tray card for lunch dated 4/8/26, directed staff to serve R1 ground honey glazed ham, pureed candied sweet potatoes, pureed roasted broccoli florets, pureed dinner roll/bread, pureed cranberry crunch bar, and nectar thickened coffee or hot tea. During an observation on 4/8/26 at 12:40 p.m., R1 was in the dining room with a plate of food in front of him. R1's plate had regular sized cooked broccoli with stems intact, minced ham with juices, pureed orange colored substance, and a pureed dessert. R1 was eating the meal with a teaspoon. Surveyor reported the wrong consistency food to NA-A. At 12:45 p.m. NA-A stated R1 had regular broccoli that was not the right diet consistency. R1 should have chopped up broccoli. NA-A stated she would remove the broccoli and take it to the kitchen so that it could be made to the right consistency. At 12:48 p.m., NA-A had not removed broccoli from R1's plate and R1 took a piece of broccoli and ate it. NA-A took R1's broccoli from his plate and returned to the dining room at 12:52 p.m., with a plate of chopped broccoli that she gave to R1. During an interview on 4/8/26 at 1:19 p.m., registered dietician (D)-A stated residents on dysphagia mechanical soft diet should have broccoli chopped up. D-A verified R1 was on a dysphagia mechanical soft diet and R1 should have been served chopped up broccoli at lunch, not regular broccoli. During interview on 4/8/26 at 3:52 p.m., cook (CK)-B stated the food they made was based on a production count report. CK-B stated meal tickets were set on meal trays to indicate what food and drinks the residents needed, but the trays often had food which did not match the meal tickets. During an interview on 4/9/26 at 10:38 a.m., CK-A stated mechanical soft food was ground very fine and the vegetables & bread would be a creamy, blended texture. CK-A also stated chopped food would be considered mechanically soft. "Chopped means knife and mechanical with blender will be finer and they use that terminology for the cooks." During an interview on 4/9/26 at 10:55 a.m., dietary manager (DM)-A stated ground texture was very	F0803		05/08/2026

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F0803 SS = J	Continued from page 9 small, bite size pieces consistent with sloppy joe or taco meat. Puree food is put through “the chopper” and is baby food consistency. Mechanical soft texture is not pureed but a little more than ground consistency. If a resident had a mixture of textured foods, the diet ticket would have “special texture” on it which indicated the meat was pureed and the rest of the food would be mechanical soft. R1’s diet ticket was for ground meat and pureed everything else. DM-A’s dietary computer system identified R1 had mechanically soft textured food and nectar thickened liquids. DM-A stated she updated the order on 4/8/26, the day after R1 had returned from a hospital stay. DM-A was unsure why R1’s diet ticket stated pureed and ground texture. DM-A reviewed the information in the computer, printed a diet ticket, and the ticket printed pureed. “It is saying mechanical soft so why it is printing pureed anything is beyond me”. DM-A stated she was going to remove R1 from the system, add him again, print off the ticket, and review the diet ticket with CK-A. DM-A reviewed the diet ticket from 3/26/26, and stated R1 had ground Philly steak with a pureed hot dog bun. DM-A stated she did not have access to the facility electronic health record and relied on nursing staff to bring a handwritten diet communication form to her when a resident admitted or had a diet change. DM-A was currently training a dietary aide on the computer system to add residents and diet orders so that she was not the only one doing it. During an interview on 4/9/26 at 12:41 p.m., NA-E stated if she questioned a resident’s prescribed diet order, she would look it up on the Kardex. NA-E reviewed R1’s Kardex. NA-E stated R1’s Kardex identified to provide supervision, small bites, used a small spoon, R1 pocketed food, and to report to nurse if something changed. NA-E stated she assumed R1’s meal ticket should say small, easy to chew bites. After the meal, R1 should rinse his mouth or brush his teeth. “He’s not thickened liquids so not worried but if he was I would look to make sure he doesn’t have thin liquids”. NA-E reviewed and verified R1’s Kardex did not identify he was on thickened liquids which was inconsistent with the diet order dated 4/1/26. During an interview on 4/9/26 at 12:46 p.m., trained medication aide (TMA)-A stated if she was unsure of a resident’s diet she would ask staff that were more familiar with the resident and verify the diet with the dietary meal ticket. TMA-A would notify the nurse manager if the Kardex and dietary ticket did not match. TMA-A stated if a resident had a change to the care plan, staff would be notified on a paper	F0803		05/08/2026

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F0803 SS = J	Continued from page 10 sheet that NAs would typically sign to verify they were updated. During an observation on 4/9/26 at 12:55 p.m., NA-E asked RN-B which residents were on thickened liquids. NA-E stated only R1 was on thickened liquids but then corrected himself and stated that R1 and R6 were the only two residents on thickened liquids. During an interview on 4/9/26 at 12:56 p.m., RN-B stated the meal trays come with a ticket and each resident has one printed. The ticket identified what the resident requested to eat and their diet type. RN-B told NA-E who had thickened liquids because she was temporary agency staff and not facility staff, RN-B reported she did not know the residents very well. R6's face sheet dated 4/10/26, identified diagnoses of unspecified dementia, and dysphagia of the oral (voluntary control of chewing, bolus formation, and moving food to back of mouth) and oropharyngeal (difficulty swallowing) phases. R6's comprehensive MDS dated 2/16/26, identified R6 had moderate cognitive impairment. R6 required setup or clean-up assistance with eating. R6 had a mechanically altered diet and no natural teeth. R6's care plan dated 10/21/25, identified risk of inadequate oral intake due to hospice status. R6 would not exhibit chewing or swallowing problems with current diet texture as evidenced by no signs or symptoms of aspiration, choking, or complaints of difficulty eating. Interventions included on 1/8/26, pureed diet and nectar thick daughter request (speech order). R6's physician order dated 2/27/26, identified regular diet, pureed texture and nectar thick liquids. R6's Visual/Bedside Kardex Report (abbreviated care plan) dated 4/10/26, identified a section titled Eating/Meals that included: provide diet as ordered. 1/8/26, pureed diet and NECTAR thick daughter request (speech order). During an observation and interview on 4/9/26 at 1:06 p.m., R1 and R6 were in the dining room, sitting at their respective tables, waiting for lunch to be served. R6's diet slip directed staff to serve nectar thick liquids and pureed food. R6 was drinking a white, thin liquid substance from a coffee cup. At 1:09 p.m., R6 began repeatedly coughing and spitting the liquid out. Surveyor intervened reported	F0803		05/08/2026

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F0803 SS = J	Continued from page 11 the concern to TMA-A who went to R6, looked in the cup and stated she would have to review the Kardex and diet ticket to know what consistency liquids R6 required. RN-B also went to R6's table and looked in her coffee cup. RN-B stated R6 had regular, thin consistency hot milk in her coffee cup. RN-B removed R6's coffee cup and took it to the kitchenette to thicken it. R6 continued to cough and have a runny nose. R6 was coughing up thick, white phlegm onto her shirt and napkin. At 1:14 p.m., RN-B returned R6's thickened milk to her, did not perform a respiratory assessment and walked away. NA-E and TMA-A handed out trays to residents at their tables while R6 continued to cough. At 1:17 p.m., TMA-A delivered R1's food to him in the dining room. R1's tray ticket identified ground chicken and pureed everything else. All the words were crossed off and handwritten "all mechanical soft according to orders". R1's plate had pureed consistency food. Surveyor intervened -reported the concern to TMA-A who stated R1's liquid was more of a honey consistency than nectar consistency, and R1 had the wrong diet consistency on his plate. TMA-A questioned if the handwritten order on the diet slip was the most up to date. TMA-A questioned RN-B on which consistency of food R1 should have. RN-B reviewed R1's chart and confirmed R1 should have nectar thick liquid and mechanical soft diet. RN-B stated R1 "does aspirate pretty easily" so the pureed diet was "not a bad thing but not what was ordered". At 1:21 p.m., RN-B called the kitchen to verify the pureed food was what R1 was supposed to have. Dietary aide (DA)-B verified R1 received the wrong meal and liquids and walked away without providing R1's correct diet type. At 1:27 p.m., R1 continued to eat the pureed with a teaspoon and coughed after taking a bite. At 1:42 p.m., DA-A came to the dining room with a new plate of food. DA-A removed the lid on the tray and the food was the same pureed food consistency that R1 was already eating. DA-A stated dietary manager (DM)-A gave her the meal. NA-E and RN-B verified the meal was still incorrect according to the ticket. At 1:46 p.m., DM-A came to the dining room and examined R1's meal and orange juice and stated it was the wrong consistency according to his diet and liquid orders. DM-A stated prepackaged nectar thick orange juice was in the refrigerator and staff must not have been aware. During an interview on 4/10/26 at 11:24 a.m., hospice case manager (HCM)-A stated hospice would want to know if there were concerns of R6 aspirating. HCM-A reviewed R6's chart and stated hospice had not been contacted about R6's aspirating/coughing incident with her liquids. "This	F0803		05/08/2026

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F0803 SS = J	Continued from page 12 was news to us". During an interview on 4/9/26 at 1:24 p.m., registered nurse (RN)-C stated residents received their meals according to the meal ticket placed on their meal trays. Staff referred to the care plan to know the most up to date diet for residents. When residents received the incorrect diet type, staff would replace the meal then education was provided to nursing and kitchen staff. RN-C stated staff could downgrade a resident's diet but not upgrade a diet. Residents with aspiration risk ate where staff could supervise them or staff were to stay in residents' rooms for supervision with meals. When residents at risk for aspiration refused to get out of bed or go to dining room area to eat, staff would attempt to reapproach/redirect. RN-C stated residents with aspiration risk worked with speech therapy, and therapy communicated recommended interventions to staff verbally or with a paper communication log kept at the nursing station. During an interview on 4/9/26 at 5:16 p.m., the director of nursing (DON) stated all residents needed some supervision to eat related to age and body reflexes not as strong. A stroke placed a resident at high risk and needed supervision. Residents were encouraged to come out of their rooms to eat but ate with their head of bed up if they chose to eat in bed. The facility did not have enough "manpower" to sit in residents' rooms every meal when the residents chose not to come out to the dining area. Speech therapy communicated recommendations through one-to-one conversation and a document placed in a binder at the nursing station. Recommendations were communicated to the DON and nurse managers and care planned. The DON expected staff to follow diet orders and intervene immediately if given an incorrect diet. During a follow-up interview on 4/10/26 at 8:16 a.m., NM-A stated R1 ate in bed a lot. NM-A stated it would not be a good idea to have R1 eat in bed as he had a recent stroke and dysphagia. NM-A stated without direct supervision while eating and drinking staff would not know if R1 was following safe strategies with eating and drinking. NM-A stated the facility could not provide enough aides to supervise R1 when he ate in his room. NM-A stated the facility would complete Risk versus Benefits for residents that eat in their rooms but residents with dysphagia need to eat in the dining room. During an interview on 4/10/25 at 8:21 a.m., NA-D stated speech therapy recommendations were found under their kiosk with the care plan. NA-D stated	F0803		05/08/2026

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F0803 SS = J	Continued from page 13 resident meal tickets reflected what residents needed for meals. NA-D reviewed a report sheet and stated the report should tell them what kind of assistance the residents needed with meals and who was at risk for choking but did not. LPN-D entered the interview and showed NA-D to look on the banner in the computer for any special instructions on diets and meals. LPN-D stated staff checked resident care plans and Kardex. LPN-D and NA-D reviewed R1's banner which identified R1 required "nectar thickened liquids and dys mech (dysphagia mechanical) soft textures" and did not include any other special instructions. During a follow-up interview on 4/10/26 at 11:22 a.m., the DON expected staff to attend to resident coughing or choking as soon as possible. The DON expected nursing assistants to stay with coughing or choking residents until a nurse was present. The nurse was to assess if the resident was coughing or choking to ensure their airway was clear and see if resident was able to clear airway on own, sit resident up if not already, and instruct resident to tuck their chin. If the resident did not clear airway on own, then nurses performed the Helmich maneuver and progressed to CPR (cardiopulmonary resuscitation) and called 911 if needed. The nurse was to enter a progress note to communicate what occurred. Staff referred residents to speech therapy to determine if they required any diet changes and were to notify the provider. Nurses were able to downgrade resident diets if needed before further evaluated. The DON stated it was important to ensure residents received nutrition in the safest way possible. During an interview on 4/9/26 at 3:20 p.m., the medical director (MD) expected staff and residents to follow resident orders. The MD stated residents have the right to refuse orders and expected the facility to notify the provider group of refusals. The MD expected the facility to notify the provider if residents' family members did not follow provider orders. The MD expected the facility to follow their policies and procedures for speech therapy recommendations and stated the providers normally wrote an order for agreed upon speech therapy recommendations. The MD stated the level of risk for not following orders of a resident at risk for aspiration depended on the specific resident and orders. The facility policy Foreign Body Airway Obstruction Management (Choking) dated 2024, identified residents with impaired swallowing, neurological disorders or dental issues were at an increased risk	F0803		05/08/2026

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F0803 SS = J	Continued from page 14 for foreign body airway obstruction and timely intervention to relieve obstruction was imperative to offset complications. The policy directed the facility to determine which residents were at a higher risk for foreign body obstruction/choking episodes and care plan accordingly. Consult a speech language pathologist as needed. The facility was to ensure residents with impaired swallowing issues and were on an altered diet received the appropriate diet. The facility policy Therapeutic Diet Orders undated, identified the facility provided all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences. The policy identified dietary and nursing staff were responsible for providing diets in the appropriate form and/or the appropriate nutritive content as prescribed. The IJ that began on 3/26/26 was removed when it was determined and verified through observation, interview and document review the facility implemented the following on 4/11/26: Help ticket placed by dietary manager to resolve the issue of tray tracker inconsistencies with tray tickets. Audit completed of tray tickets to ensure the match dietary orders completed 4/10/26. Progress notes from the past 30 days reviewed to ensure no other choking incidents documented on 4/6/26. Residents that receive mechanically altered diets received education on importance of being out of bed and in dining room for meals. Audit completed by therapy department on all residents with recommended supervision. Care plans/Kardex updated to indicate supervision required. Education with clinical staff on mechanically altered diet policy, diet consistency, verifying correct diet accuracy prior to serving meals, supervision during meals, change of condition assessment on 4/10/26-4/13/26. Speech communication will include verification of what specific supervision is needed for those with	F0803		05/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245184	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Restorative Care Center	**501 EIGHTH AVENUE SOUTHEAST , ROCHESTER, Minnesota, 55904**

(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
F0803 SS = J	Continued from page 15 altered diets and will be given verbally to nursing staff, written on Therapy Communication to Nursing form, and uploaded into residents medical record, care plan, and staff tasks to complete. Nurse will be present in dining room for meals to ensure appropriate diets are served and monitor residents for choking. Residents on mechanically altered diet will have supervision while eating. Care plans updated for staff to provide supervision while eating. Education with dietary staff on diet consistencies and serving the appropriate diet per tray ticket. Audits to ensure compliance.	F0803		05/08/2026

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NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES

6/26/2026

Administrator
Rochester Restorative Care Center
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: 22D6D9-H3

Dear Administrator:

On May 11, 2026, a Notice of Assessment for Noncompliance with Correction Orders with an imposed a daily fine in the amount of $350.00 was electronically issued to the above facility. An acknowledgement was electronically received by the Department stating that the violation had been corrected. A reinspection was held on May 26, 2026, and it was determined that compliance with the licensing rules was attained.

Therefore, the total amount of the assessment is $2,450.00. In accordance with Minnesota Statutes, § 144A.10, subdivision 7, the costs of the reinspection, totaling $249.40, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Minnesota Department of Health in the amount of $2,699.40 within 15 days of the receipt of this notice.

Please send a copy of this letter and the check to:

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64975
Financial Management
St. Paul MN 55164-0975

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

cc: Shellae Dietrich, Program Assurance Supervisor
Kami Fiske-Downing, Licensing and Certification Program
HRD Deposit Team

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 25, 2026

Administrator
Rochester Restorative Care Center
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: CCN: 245184
Cycle Start Date: March 12, 2026

Dear Administrator:

On April 29, 2026, we notified you a remedy was imposed.

On June 1, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 18, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 14, 2026, be discontinued as of May 18, 2026. (42 CFR 488.417 (b))

In our letter of April 29, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 14, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division

Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us