Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 5, 2025

Administrator
AUGUSTANA CARE HASTINGS HEALTH AND REHABILITATION

930 WEST 16TH STREET
HASTINGS, MN 55033

RE: CCN:245224
Cycle Start Date: December 5, 2025

Dear Administrator:

On December 5, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);

- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, 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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 5, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 5, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine

that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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930 WEST 16TH STREET
HASTINGS, MN 55033

Re: State Nursing Home Licensing Orders
Event ID: 1D9678-H1

Dear Administrator:

The above facility survey was completed on December 5, 2025 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:

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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.

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Please feel free to call me with any questions.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245224	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/05/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 10/16/25 and 10/20/25, 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. H52245304C (2629736) with a deficiency issued at F684. 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		12/16/2025
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 assess and monitor non-pressure related skin injuries for changes until resolved for 1 of 3 (R1), reviewed for quality of care. Findings include: Findings include:	F0684	F684 Plan of Correction It is the policy of Cassia to comply with the regulation cited under F684. To assure continued compliance, the following plan has been put into place: The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: Resident 1 skin status has been comprehensively assessed and the plan of care updated with appropriate interventions implemented. Resident 1 expired Actions taken to identify other potential residents having similar occurrences: Current residents with non-pressure related skin breakdown have been reviewed and comprehensively assessed. The plans of care have been updated as indicated including appropriate interventions and	12/16/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245224	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/05/2025

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F0684 SS = D	Continued from page 1 R1's annual Minimum Data Set (MDS), dated 8/14/25, identified R1's cognition was intact and had diagnoses of multiple sclerosis (MS)- (an autoimmune disease where your immune system mistakenly attacks the protective covering of your nerves (called myelin) in the brain and spinal cord producing symptoms such as fatigue, walking difficulties, numbness, and muscle weakness), diabetes, congestive heart failure and pyoderma gangrenosum (a rare disease where a person's immune system attacks its own skin, causing extremely painful, rapidly spreading ulcers or sores, most often on the legs). Further indicated R1had open lesions other than ulcers, rashes, cuts…and Moisture Associated Skin Damage (MASD) that required applications of ointment/medications and nonsurgical dressings other than to feet. R1's care plan dated 9/30/24, identified a problem at risk for moisture due to incontinence of bladder and/or bowel, decreased activity, immobility, shear and friction. Other risk factors: recent ADL decline, MS, cardiovascular disease, depression, diabetes, polyneuropathy, pain, shortness of breath, required assist with activities of daily living (ADL)s, congestive heart failure (CHF), and Pyoderma Gangrenosum and admitted to the facility with several lesions on her body. Also has a history of MASD to her buttocks. Followed by Dermatology since 2/2024 for Pyoderma Gangrenosum lesions (neck, midback, right shin and abdomen). At times have refused treatments. Interventions dated 9/20/24 include to provide treatment per physician orders, involve and educate R1 and family in prevention/treatment methods related to skin integrity, NAR/CNA to observe daily during cares and notify nurse promptly of any areas of concern. R1's Visual Body Inspection note dated 9/17/25, identified R1 had no new skin concerns at this time. R1's Wound Management note dated 9/20/25, identified R1 had a right shin rash that measured 31 centimeters (cm) x 7 cm and left shin rash measured 2.5 cm x 13 cm. Healed discontinued information: policy updated, wound management no longer required this skin alteration, Staff will continue to monitor until resolved per updated facility policy. R1's progress note dated 9/20/25 at 1:50 p.m., identified R1 was noted to have 31 centimeters (cm) X 7 cm rash from right inner lower leg to the middle of her inner thigh. A 2.5 cm x 13 cm rash from left inner lower leg to top left inner knee. R1 complained of pain to her right foot and rated it 8 out of 10. Tylenol, 650 mg prn was given for pain. Medication seems	F0684	Continued from page 1 monitoring. Comprehensive skin risk assessments will be completed for residents upon admission and hospital return. Implementation of care plan and interventions to treat any existing skin related concerns as well as interventions to prevent skin integrity concerns. Care plan interventions are based on the skin risk assessment. Visual skin checks will be completed weekly. Quarterly, annually and with resident significant change in condition will have a comprehensive skin assessment completed, and care plan related to skin integrity is reviewed and updated as indicated. Assess all wounds of pressure, arterial, venous, diabetic, neuropathic, or mixed etiology weekly Assess all other skin issues weekly and document the treatment of the area in the EHR Measures put in place to ensure deficient practice does not recur: The facility has reviewed and updated the Skin and Wound Policy. Licensed staff will be re-educated on the Skin Integrity Policy and Procedure. Effective implementation of actions will be monitored by: The nursing supervisor will audit any new admissions or hospital returns to ensure that a comprehensive wound assessment is completed is opened per facility protocol; this will occur weekly for three months to ensure compliance with routine assessments for comprehensive skin evaluations. Results of these audits will be reviewed by the facility QAPI committee, and they will make the decision if further monitoring/audits are recommended. The person responsible to maintain compliance is: Director of Nursing or designee Date of Compliance: 12/16/25	

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F0684 SS = D	Continued from page 2 effective. The rashes are not raised; they are flat and pink in color, no warmth to the touch. Provider updated through email and family-member (FM)-A at the facility visiting and stated R1 used to have that kind of rash. Will continue to monitor. R1's Visual Body Inspection note dated 9/24/25, identified R1 had no new skin concerns at this time. R1's progress note dated 9/27/25, identified R1 was sent to the hospital per provider orders. R1's hospital Consult notes dated 9/29/25, identified R1's initial wound assessment note described the wound etiology to be Pyoderma gangrenous: 1. Wound 1 location left neck, bilateral axilla, left back, abdomen, right thigh and right leg wound base appears to be scar tissue with a few small ones on the abdomen with small amount of yellow/gold/tan drainage with mild pain present. 2. Wound 2 location bilateral axilla fungal/yeast wound etiology rash with odor present. Orders to follow up weekly with wound care. R1's Hospital Discharge Summary dated 10/1/25, identified R1 was hospitalized for congestive heart failure and had new orders for the following wounds: 1. Left neck, bilateral abdomen and right thigh: cleanse wounds with normal saline and pat dry, place xeroform gauze product (non-adherent, occlusive dressing, which means it helps protect the wound, maintains a moist healing environment, and does not stick to the new tissue) over wound bed, cover with ABD pad (large, sterile, absorbent dressing used to cover large wounds or surgical incisions on the abdomen) and secure with tape, change dressings daily. 2. Left back and right anterior shin: cleanse wounds with normal saline and pat dry with non-sterile 4 x 4 gauze. Right shin cover with 4 x 4 Mepilex soft, foam bandage designed to absorb fluid from a wound). Left back cover with xeroform and a 6 x 6 Mepilex. 3. Bilateral axilla: do not use Cavilon advanced wand (a single-use foam applicator containing a unique, ultra-thin polymer barrier designed to protect and heal severely damaged or intact skin from caustic body fluids like liquid stool and gastric fluid) on this patient. Clean axilla with bath wipes and dry, apply a very thin layer of citric aid AF ointment and continue	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245224	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/05/2025

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F0684 SS = D	Continued from page 3 treatment for 2 weeks. R1's progress noted dated 10/1/25 at 9:07 p.m., identified R1 returned from hospital…no new skin concerns. R1's Visual Body Inspection note dated 10/1/25, Although the hospital discharge summary identified R1 had wounds, R1's inspection not only identified that R1's scars were visually inspected and without change, both heels intact and free of deep tissue injury (DTI) or other skin alteration. No new bruises, skin tears, moles, pressure injuries or rashes noted. R1's Physician progress note dated 10/9/25, identified R1 has Pyoderma gangrenosum, presenting with multiple open wounds, starting late 2023, currently treated with vitamin D, topical clobetasol (prescription-strength corticosteroid medication applied directly to the skin to treat severe inflammatory skin conditions) and cyclosporine (potent immunosuppressant medication that works by decreasing the activity of the immune system), follows with dermatology and the visiting wound physician. R1's wounds were not addressed on this visit. R1's Visual Body Inspection note dated 10/12/25, identified R1's scars were visually inspected and without change, both heels intact and free of deep tissue injury (DTI) or other skin alteration. No new bruises, skin tears, moles, pressure injuries or rashes noted. R1's Visual Body Inspection note dated 10/15/25, identified R1's scars were visually inspected and without change, both heels intact and free of deep tissue injury (DTI) or other skin alteration. No new bruises, skin tears, moles, pressure injuries or rashes noted. R1's Visual Body Inspection note dated 10/20/25, identified R1's scars were visually inspected and without change, both heels intact and free of deep tissue injury (DTI) or other skin alteration. No new bruises, skin tears, moles, pressure injuries or rashes noted. R1's treatment administration record (TAR) dated October 2025 identified the following: 1. Bilateral armpits: DO NOT USE CAVILON ADVANCED WAND ON THIS PATIENT 1) Clean axilla with bath wipes and dry. 2) Apply a very thin layer of Critic Aid AF ointment BID and prn to red/denuded areas. Do not scrub	F0684		

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F0684 SS = D	Continued from page 4 the skin if soiled, instead cleanse gently and apply another thin layer of Critic Aid Ointment. 3) Continue this treatment for 2 weeks. This was documented as completed from 10/1/25 to 10/15/25. 2. Left buttock: cleanse with ns, pat dry, apply skin prep to surrounding tissue, cover with 6x6 silicone adhesive dressing. Change every sun, wed and prn. This was documented as completed on 10/1/25, 10/5/25, 10/8/25, 10/12/25, 10/15/25 and 10/19/25. 3. Left mid back and right shin: cleanse with ns, pat dry, skin prep peri wound, add xeroform to wound-base on back cover with silicone adhesive dressing. Change every Sun, Wed and prn. This was documented as completed on 10/1/25, 10/5/25, 10/8/25, 10/12/25, 10/15/25 and 10/19/25. 4. Left posterior head/neck: cleanse with NS, pat dry, apply Clobetasol to wound edges as directed and Tacrolimus to center of wound as directed daily. Ensure pillowcase is clean. Replace pillowcase as needed. This was documented as completed from 10/1/25 to 10/20/25 with the exception on 10/7/25 and 10/10/25 due to resident refusal. 5. Right thigh and bilateral abdomen: 1) Cleanse wound with wound cleanser or NS and pat dry. 2)Apply Tacrolimus to center of wound then cover with xeroform gauze over wound bed. 3) Cover with 4x4 gauze and secure with tape. 4) Change dressing daily. This was documented as completed from 10/1/25 to 10/20/25 with the exception on 10/7/25 and 10/10/25 due to resident refusal. R1's record was reviewed from 9/20/25 to 10/20/25, did not include any monitoring of R1's wounds nor any weekly comprehensive skin assessments to identify interventions to protect R1's skin from further injury. In addition, it did not identify the physician was notified of R1's dressing change refusals on 10/7/25 and 10/10/25. Furthermore, the record lacked wound care follow up in 2 weeks per the hospital discharge summary on 10/1/25. During an interview on 10/16/25 at 2:25 p.m., R1 was lying bed and stated she had a rare skin disorder and had sores all over her body like her arm pits, neck, abdomen and legs. R1 stated they were painful and never go away but do get better. During an interview on 10/20/25 at 11:26 a.m., nursing assistant (NA)-A stated she hasn't worked with R1 much but when does provides cares she always notices a	F0684		

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F0684 SS = D	Continued from page 5 bandage on R1's abdomen and legs. NA-A stated she had never seen what was under the bandages. During an interview on 10/20/25 at 11:36 a.m., NA-B stated R1 had a lot of bandages on her body, to include her abdomen, right and left lower legs. NA-B stated she had never seen under the bandages. During an interview on 10/20/25 at 11:46 a.m., NA-C stated R1 had dressings on her abdomen, when she cleans R1 she has to be very careful to not bump all the bandages. NA-C stated she had never seen under the bandages. During an interview on 10/20/25 at 12:13 p.m., NA-D stated R1 had wounds on her legs, abdomen and her back. NA-D stated when the nurse does her dressing changes, she will ask for help rolling R1 but had never seen R1's wounds. During an interview on 10/20/25 at 12:22 p.m., licensed practical nurse (LPN)-A stated R1 had current wounds on her left and right abdomen, side of her left head, right thigh, left mid back and right shin that she has treatment orders for. LPN-A reviewed R1's record and was unable to find R1's weekly comprehensive wound assessments for these wounds. LPN-A stated they should include measurements, wound bed and peri wound. LPN-A stated they should be monitoring for signs and symptoms of infection and it should be done weekly. During an interview on 10/20/25 at 12:32 p.m., nurse manager (NM)-A stated for non-pressure skin wounds the nurse would initially measure the wound and document it in a skin event, call and update the family and provider to get a treatment started right away. NM-A stated we no longer measure non pressure wounds weekly; our skin policy was updated about a month ago. NM-A further stated R1 used to be followed by dermatology but was unsure of the last time she saw dermatology. During an interview on 10/20/25 at 12:54 p.m., director of nursing (DON) stated they recently had their skin policy updated which directed that staff no longer had to do weekly comprehensive skin assessments on non-pressure wounds. DON reviewed R1's record and stated R1 had multiple current wounds that are not comprehensively assessed each week to include measurements, wound base, peri wound, drainage or odor. DON was unable to articulate how staff would know if there was a change in the wound to notify the doctor without the assessments. DON further stated she was unsure the last time R1 was seen by dermatology for her wounds and was not currently followed by wound rounds.	F0684		

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F0684 SS = D	Continued from page 6 Facility policy, “Skin Integrity,” revised 10/3/25, identified a policy that Cassia seeks to utilize an interdisciplinary approach to promote best practice in areas of skin injury prevention and promotion of healing. Skin care, risk assessment and wound care treatment plans are based on resident focused goals of pressure redistribution, improved or sustained skin integrity, mobility, comfort, infection prevention, healing and/or palliation. Cassia facilities will use the Wound Management area of the MatrixCare EHR to document pressure injuries, deep tissue injuries, arterial ulcers, diabetic ulcers, venous ulcers, surgical incisions with removable dressings. Facilities with Point Click Care (PCC) will document pressure injuries, deep tissue injuries, arterial ulcers, diabetic ulcers, venous ulcers and surgical incisions in the skin and wound area of PCC. Matrix sites and PCC sites will document all other skin integrity concerns such as bruises, skin tears, rash, MASD, and surgical incisions with a non-removable dressing (ordered by the provider not to remove), etc. in the treatment section of the EHR by entering a treatment to monitor and treat the area until it is healed. The treatment will be discontinued when healed…A skin alteration event/incident report will be completed any time there is any other type of facility acquired skin concern. Surgical incisions do not require an event/incident report. Bruises that are less than the size of a quarter and are not suspicious would not need an event/incident created but should have a progress note explaining the bruise. Updates will be given to MD/NP/PA, Dietitian and resident representative monthly, or more often if area is deteriorating or not healing as expected. The provider will be updated for wounds that worsen. The provider will be updated for wounds that are stagnant for 2 weeks and will be asked to consider a change in treatment if applicable. If a bruise, skin tear or abrasion are the result of a fall, the fall event/incident report will cover those injuries and no additional skin alteration event/incident is required…Measuring/Describing wounds: 1. Location of wound 2. Type of wound 3. Length is the greatest length head to toe 4. Width is the greatest width side to side. 5. Depth is measured by inserting a moistened sterile cotton tipped applicator into the deepest portion of the wound base to measure depth in centimeters. Grasp the fully inserted applicator with the thumb and forefinger at the skin surface. Withdraw the applicator while maintaining the grasp with the thumb and forefinger at the point of the indicating depth. Measure from the tip of the applicator to the position of the thumb with a measuring tool to determine depth. 6. Tissue types -- use percentages to	F0684		

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F0684 SS = D	Continued from page 7 describe the wound bed with the following tissue types: Epithelial, granulation, eschar, intact, discolored skin, scab, callous, slough, red/pink, etc. Percentages should equal 100%.7. Undermining/tunneling is measured by gently inserting the moistened applicator to measure undermining and/or tunneling using the applicator as described in depth measuring. Measure as if the resident were a clock and the head is 12 o'clock. Measure undermining by measuring the extent of the undermining clockwise then the deepest part of the undermining. For example: 1.5 cm from 2-7 o'clock. Measure tunneling by measuring the depth of the tunnel and give direction of the tunnel by the clock method. For example, 3 cm at 3 o'clock. If there is more than 1 tunnel, number each clockwise…9. Thickness of injury (for non-pressure related ulcers): Document if the wound is partial thickness (isolated to the skin), or full thickness (below the skin) 10. Drainage, document amount of drainage such as no drainage, scant, small, moderate, large or copious. 11. Drainage, document type of drainage such as no drainage, serous, sero-sanguinous, sanguineous, purulent, or other (Describe). 12. Document odor from wound after the dressing has been removed and the wound has been cleansed. Do not document odor from the dressing. 13. Document presence of pain at site of the wound. 14. Describe wound edges (e.g. black, calloused, denuded, erythematous, or rolled). 15. Describe the peri wound area up to 4 cm from the edge of the wound. Measure in centimeters. Describe the characteristics of the surrounding skin (e.g. intact, denuded, erythematous, indurated, macerated). 16. Document progress to healing in the past week (e.g. improved, no change, worsening) for the following: Pressure injury, deep tissue injuries, arterial ulcers, diabetic ulcers, venous ulcers, surgical incisions. If the surgical incision has a dressing that is ordered by the provider not to be removed, you will not document progress to healing.	F0684		

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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 10/16/25 and 10/20/25, 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.	20000		12/16/2025

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

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20000	Continued from page 1 The following complaints were reviewed. H52245304C (2629736) with a licensing order issued at 0830. 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.	20000		
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 review the	20830	Completed	12/16/2025

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20830	Continued from page 2 facility failed to assess and monitor non-pressure related skin injuries for changes until resolved for 1 of 3 (R1), reviewed for quality of care. Findings include: R1's annual Minimum Data Set (MDS), dated 8/14/25, identified R1's cognition was intact and had diagnoses of multiple sclerosis (MS)- (an autoimmune disease where your immune system mistakenly attacks the protective covering of your nerves (called myelin) in the brain and spinal cord producing symptoms such as fatigue, walking difficulties, numbness, and muscle weakness), diabetes, congestive heart failure and pyoderma gangrenosum (a rare disease where a person's immune system attacks its own skin, causing extremely painful, rapidly spreading ulcers or sores, most often on the legs). Further indicated R1had open lesions other than ulcers, rashes, cuts…and Moisture Associated Skin Damage (MASD) that required applications of ointment/medications and nonsurgical dressings other than to feet. R1's care plan dated 9/30/24, identified a problem at risk for moisture due to incontinence of bladder and/or bowel, decreased activity, immobility, shear and friction. Other risk factors: recent ADL decline, MS, cardiovascular disease, depression, diabetes, polyneuropathy, pain, shortness of breath, required assist with activities of daily living (ADL)s, congestive heart failure (CHF), and Pyoderma Gangrenosum and admitted to the facility with several lesions on her body. Also has a history of MASD to her buttocks. Followed by Dermatology since 2/2024 for Pyoderma Gangrenosum lesions (neck, midback, right shin and abdomen). At times have refused treatments. Interventions dated 9/20/24 include to provide treatment per physician orders, involve and educate R1 and family in prevention/treatment methods related to skin integrity, NAR/CNA to observe daily during cares and notify nurse promptly of any areas of concern. R1's Visual Body Inspection note dated 9/17/25, identified R1 had no new skin concerns at this time. R1's Wound Management note dated 9/20/25, identified R1 had a right shin rash that measured 31 centimeters (cm) x 7 cm and left shin rash measured 2.5 cm x 13 cm. Healed discontinued information: policy updated, wound management no longer required this skin alteration, Staff will continue to monitor until resolved per updated facility policy. R1's progress note dated 9/20/25 at 1:50 p.m.,	20830		

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20830	Continued from page 3 identified R1 was noted to have 31 centimeters (cm) X 7 cm rash from right inner lower leg to the middle of her inner thigh. A 2.5 cm x 13 cm rash from left inner lower leg to top left inner knee. R1 complained of pain to her right foot and rated it 8 out of 10. Tylenol, 650 mg prn was given for pain. Medication seems effective. The rashes are not raised; they are flat and pink in color, no warmth to the touch. Provider updated through email and family-member (FM)-A at the facility visiting and stated R1 used to have that kind of rash. Will continue to monitor. R1's Visual Body Inspection note dated 9/24/25, identified R1 had no new skin concerns at this time. R1's progress note dated 9/27/25, identified R1 was sent to the hospital per provider orders. R1's hospital Consult notes dated 9/29/25, identified R1's initial wound assessment note described the wound etiology to be Pyoderma gangrenous: 1. Wound 1 location left neck, bilateral axilla, left back, abdomen, right thigh and right leg wound base appears to be scar tissue with a few small ones on the abdomen with small amount of yellow/gold/tan drainage with mild pain present. 2. Wound 2 location bilateral axilla fungal/yeast wound etiology rash with odor present. Orders to follow up weekly with wound care. R1's Hospital Discharge Summary dated 10/1/25, identified R1 was hospitalized for congestive heart failure and had new orders for the following wounds: 1. Left neck, bilateral abdomen and right thigh: cleanse wounds with normal saline and pat dry, place xeroform gauze product (non-adherent, occlusive dressing, which means it helps protect the wound, maintains a moist healing environment, and does not stick to the new tissue) over wound bed, cover with ABD pad (large, sterile, absorbent dressing used to cover large wounds or surgical incisions on the abdomen) and secure with tape, change dressings daily. 2. Left back and right anterior shin: cleanse wounds with normal saline and pat dry with non-sterile 4 x 4 gauze. Right shin cover with 4 x 4 Mepilex soft, foam bandage designed to absorb fluid from a wound). Left back cover with xeroform and a 6 x 6 Mepilex. 3. Bilateral axilla: do not use Cavilon advanced wand	20830		

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20830	Continued from page 4 (a single-use foam applicator containing a unique, ultra-thin polymer barrier designed to protect and heal severely damaged or intact skin from caustic body fluids like liquid stool and gastric fluid) on this patient. Clean axilla with bath wipes and dry, apply a very thin layer of citric aid AF ointment and continue treatment for 2 weeks. R1's progress noted dated 10/1/25 at 9:07 p.m., identified R1 returned from hospital…no new skin concerns. R1's Visual Body Inspection note dated 10/1/25, Although the hospital discharge summary identified R1 had wounds, R1's inspection not only identified that R1's scars were visually inspected and without change, both heels intact and free of deep tissue injury (DTI) or other skin alteration. No new bruises, skin tears, moles, pressure injuries or rashes noted. R1's Physician progress note dated 10/9/25, identified R1 has Pyoderma gangrenosum, presenting with multiple open wounds, starting late 2023, currently treated with vitamin D, topical clobetasol (prescription-strength corticosteroid medication applied directly to the skin to treat severe inflammatory skin conditions) and cyclosporine (potent immunosuppressant medication that works by decreasing the activity of the immune system), follows with dermatology and the visiting wound physician. R1's wounds were not addressed on this visit. R1's Visual Body Inspection note dated 10/12/25, identified R1's scars were visually inspected and without change, both heels intact and free of deep tissue injury (DTI) or other skin alteration. No new bruises, skin tears, moles, pressure injuries or rashes noted. R1's Visual Body Inspection note dated 10/15/25, identified R1's scars were visually inspected and without change, both heels intact and free of deep tissue injury (DTI) or other skin alteration. No new bruises, skin tears, moles, pressure injuries or rashes noted. R1's Visual Body Inspection note dated 10/20/25, identified R1's scars were visually inspected and without change, both heels intact and free of deep tissue injury (DTI) or other skin alteration. No new bruises, skin tears, moles, pressure injuries or rashes noted. R1's treatment administration record (TAR) dated	20830		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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20830	Continued from page 5 October 2025 identified the following: 1. Bilateral armpits: DO NOT USE CAVILON ADVANCED WAND ON THIS PATIENT 1) Clean axilla with bath wipes and dry. 2) Apply a very thin layer of Critic Aid AF ointment BID and prn to red/denuded areas. Do not scrub the skin if soiled, instead cleanse gently and apply another thin layer of Critic Aid Ointment. 3) Continue this treatment for 2 weeks. This was documented as completed from 10/1/25 to 10/15/25. 2. Left buttock: cleanse with ns, pat dry, apply skin prep to surrounding tissue, cover with 6x6 silicone adhesive dressing. Change every sun, wed and prn. This was documented as completed on 10/1/25, 10/5/25, 10/8/25, 10/12/25, 10/15/25 and 10/19/25. 3. Left mid back and right shin: cleanse with ns, pat dry, skin prep peri wound, add xeroform to wound-base on back cover with silicone adhesive dressing. Change every Sun, Wed and prn. This was documented as completed on 10/1/25, 10/5/25, 10/8/25, 10/12/25, 10/15/25 and 10/19/25. 4. Left posterior head/neck: cleanse with NS, pat dry, apply Clobetasol to wound edges as directed and Tacrolimus to center of wound as directed daily. Ensure pillowcase is clean. Replace pillowcase as needed. This was documented as completed from 10/1/25 to 10/20/25 with the exception on 10/7/25 and 10/10/25 due to resident refusal. 5. Right thigh and bilateral abdomen: 1) Cleanse wound with wound cleanser or NS and pat dry. 2)Apply Tacrolimus to center of wound then cover with xeroform gauze over wound bed. 3) Cover with 4x4 gauze and secure with tape. 4) Change dressing daily. This was documented as completed from 10/1/25 to 10/20/25 with the exception on 10/7/25 and 10/10/25 due to resident refusal. R1's record was reviewed from 9/20/25 to 10/20/25, did not include any monitoring of R1's wounds nor any weekly comprehensive skin assessments to identify interventions to protect R1's skin from further injury. In addition, it did not identify the physician was notified of R1's dressing change refusals on 10/7/25 and 10/10/25. Furthermore, the record lacked wound care follow up in 2 weeks per the hospital discharge summary on 10/1/25. During an interview on 10/16/25 at 2:25 p.m., R1 was lying bed and stated she had a rare skin disorder and had sores all over her body like her arm pits, neck,	20830		

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20830	Continued from page 6 abdomen and legs. R1 stated they were painful and never go away but do get better. During an interview on 10/20/25 at 11:26 a.m., nursing assistant (NA)-A stated she hasn't worked with R1 much but when does provides cares she always notices a bandage on R1's abdomen and legs. NA-A stated she had never seen what was under the bandages. During an interview on 10/20/25 at 11:36 a.m., NA-B stated R1 had a lot of bandages on her body, to include her abdomen, right and left lower legs. NA-B stated she had never seen under the bandages. During an interview on 10/20/25 at 11:46 a.m., NA-C stated R1 had dressings on her abdomen, when she cleans R1 she has to be very careful to not bump all the bandages. NA-C stated she had never seen under the bandages. During an interview on 10/20/25 at 12:13 p.m., NA-D stated R1 had wounds on her legs, abdomen and her back. NA-D stated when the nurse does her dressing changes, she will ask for help rolling R1 but had never seen R1's wounds. During an interview on 10/20/25 at 12:22 p.m., licensed practical nurse (LPN)-A stated R1 had current wounds on her left and right abdomen, side of her left head, right thigh, left mid back and right shin that she has treatment orders for. LPN-A reviewed R1's record and was unable to find R1's weekly comprehensive wound assessments for these wounds. LPN-A stated they should include measurements, wound bed and peri wound. LPN-A stated they should be monitoring for signs and symptoms of infection and it should be done weekly. During an interview on 10/20/25 at 12:32 p.m., nurse manager (NM)-A stated for non-pressure skin wounds the nurse would initially measure the wound and document it in a skin event, call and update the family and provider to get a treatment started right away. NM-A stated we no longer measure non pressure wounds weekly; our skin policy was updated about a month ago. NM-A further stated R1 used to be followed by dermatology but was unsure of the last time she saw dermatology. During an interview on 10/20/25 at 12:54 p.m., director of nursing (DON) stated they recently had their skin policy updated which directed that staff no longer had to do weekly comprehensive skin assessments on non-pressure wounds. DON reviewed R1's record and stated R1 had multiple current wounds that are not comprehensively assessed each week to include	20830		

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20830	Continued from page 7 measurements, wound base, peri wound, drainage or odor. DON was unable to articulate how staff would know if there was a change in the wound to notify the doctor without the assessments. DON further stated she was unsure the last time R1 was seen by dermatology for her wounds and was not currently followed by wound rounds. Facility policy, “Skin Integrity,” revised 10/3/25, identified a policy that Cassia seeks to utilize an interdisciplinary approach to promote best practice in areas of skin injury prevention and promotion of healing. Skin care, risk assessment and wound care treatment plans are based on resident focused goals of pressure redistribution, improved or sustained skin integrity, mobility, comfort, infection prevention, healing and/or palliation. Cassia facilities will use the Wound Management area of the MatrixCare EHR to document pressure injuries, deep tissue injuries, arterial ulcers, diabetic ulcers, venous ulcers, surgical incisions with removable dressings. Facilities with Point Click Care (PCC) will document pressure injuries, deep tissue injuries, arterial ulcers, diabetic ulcers, venous ulcers and surgical incisions in the skin and wound area of PCC. Matrix sites and PCC sites will document all other skin integrity concerns such as bruises, skin tears, rash, MASD, and surgical incisions with a non-removable dressing (ordered by the provider not to remove), etc. in the treatment section of the EHR by entering a treatment to monitor and treat the area until it is healed. The treatment will be discontinued when healed…A skin alteration event/incident report will be completed any time there is any other type of facility acquired skin concern. Surgical incisions do not require an event/incident report. Bruises that are less than the size of a quarter and are not suspicious would not need an event/incident created but should have a progress note explaining the bruise. Updates will be given to MD/NP/PA, Dietitian and resident representative monthly, or more often if area is deteriorating or not healing as expected. The provider will be updated for wounds that worsen. The provider will be updated for wounds that are stagnant for 2 weeks and will be asked to consider a change in treatment if applicable. If a bruise, skin tear or abrasion are the result of a fall, the fall event/incident report will cover those injuries and no additional skin alteration event/incident is required…Measuring/Describing wounds: 1. Location of wound 2. Type of wound 3. Length is the greatest length head to toe 4. Width is the greatest width side to side. 5. Depth is measured by inserting a moistened sterile cotton tipped applicator into the deepest portion of the wound base to measure depth in centimeters. Grasp the fully inserted applicator with	20830		

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20830	Continued from page 8 the thumb and forefinger at the skin surface. Withdraw the applicator while maintaining the grasp with the thumb and forefinger at the point of the indicating depth. Measure from the tip of the applicator to the position of the thumb with a measuring tool to determine depth. 6. Tissue types -- use percentages to describe the wound bed with the following tissue types: Epithelial, granulation, eschar, intact, discolored skin, scab, callous, slough, red/pink, etc. Percentages should equal 100%.7. Undermining/tunneling is measured by gently inserting the moistened applicator to measure undermining and/or tunneling using the applicator as described in depth measuring. Measure as if the resident were a clock and the head is 12 o'clock. Measure undermining by measuring the extent of the undermining clockwise then the deepest part of the undermining. For example: 1.5 cm from 2-7 o'clock. Measure tunneling by measuring the depth of the tunnel and give direction of the tunnel by the clock method. For example, 3 cm at 3 o'clock. If there is more than 1 tunnel, number each clockwise…9. Thickness of injury (for non-pressure related ulcers): Document if the wound is partial thickness (isolated to the skin), or full thickness (below the skin) 10. Drainage, document amount of drainage such as no drainage, scant, small, moderate, large or copious. 11. Drainage, document type of drainage such as no drainage, serous, sero-sanguinous, sanguineous, purulent, or other (Describe). 12. Document odor from wound after the dressing has been removed and the wound has been cleansed. Do not document odor from the dressing. 13. Document presence of pain at site of the wound. 14. Describe wound edges (e.g. black, calloused, denuded, erythematous, or rolled). 15. Describe the peri wound area up to 4 cm from the edge of the wound. Measure in centimeters. Describe the characteristics of the surrounding skin (e.g. intact, denuded, erythematous, indurated, macerated). 16. Document progress to healing in the past week (e.g. improved, no change, worsening) for the following: Pressure injury, deep tissue injuries, arterial ulcers, diabetic ulcers, venous ulcers, surgical incisions. If the surgical incision has a dressing that is ordered by the provider not to be removed, you will not document progress to healing. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for non-pressure skin concerns to assure they are receiving the necessary treatment/services to prevent non-pressure related skin concerns from developing and to promote healing. 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	20830		

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20830	Continued from page 9 ensure appropriate care and services are implemented and reduce the risk for non-pressure skin concern 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.	20830		