DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 29, 2025

Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN 55387

RE: CCN: 245234
Cycle Start Date: February 27, 2025

Dear Administrator:

On April 24, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

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April 29, 2025

Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN 55387

Re: Reinspection Results
Event ID: VWNX12

Dear Administrator:

On April 24, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 27, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Protecting, Maintaining and Improving the Health of All Minnesotans

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March 10, 2025

Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN 55387

RE: CCN: 245234
Cycle Start Date: February 27, 2025

Dear Administrator:

On February 27, 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:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102 Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 May 27, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 27, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections

488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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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March 10, 2025

Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN 55387

Re: State Nursing Home Licensing Orders
Event ID: VWNX11

Dear Administrator:

The above facility was surveyed on February 25, 2025 through February 27, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102 Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	C 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 2/25/25 through 2/27/25, 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: H52347601C (MN110688) with a deficiency cited at F687 and incidental finding at F686, and H52348822C (MN111006) 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.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		3/27/25

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

Electronically Signed | 03/20/2025

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

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F 686	Continued From page 1 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess wounds with measurements and consistently implement interventions to promote healing of current pressure ulcers (PU) for 1 of 3 residents (R3). Findings include: R3's quarterly minimum data set dated 2/13/25 indicated severe cognitive impairment, required substantial assistance with footwear, had one unhealed Stage 3 PU (full thickness loss of skin) and at risk for developing more, and did not exhibit rejection of care behaviors. R3's care plan dated 2/10/25, indicated R3 had a Stage 3 pressure ulcer to her left lateral (outer side) ankle with interventions included provide pressure reducing mattress and pressure reducing cushion in wheelchair, notify nurse immediately of any new areas of skin breakdown, R3 had an activities of daily living (ADL) performance deficit with interventions included resident requires assistance of one staff apply surgical shoe on right foot and shoe on left foot. R3's care plan lacks information about an off-loading boot to her left foot while she is in bed. R3's physician orders summary dated 2/26/24, instructed staff to apply heel boot to left foot at night and anytime when in bed during the day. Okay to remove when sitting in wheelchair. An	F 686	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R3 wound assessment and interventions put in the care plan immediately. Also, staff were educated on the interventions put in place. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents in the facility have the potential to be affected by the deficient practice. Specifically, all residents with skin issues have potential to be affected by the deficient practice. As a result, facility audited all residents skin and ensured interventions are in place. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. To ensure systemic changes are sustained all nursing staff have been educated on the GSS policy- Pressure Ulcers- R/S, LTC, Therapy & Rehab policy by the DNS/designee. Education includes - CNAs are directed to follow interventions outlined on the POC/Kardex. This includes ensuring any pressure relieving/reducing devices are used as directed. Nursing assistants should report any problems or refusals to the licensed nurse. Licensed nurses must complete	

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F 686	Continued From page 2 additional provider order instructed wear a surgical shoe to right foot. R3's physician order summary also included an order to change dressing to left lateral ankle wound every other day. On 2/26/25 at 10:48 a.m., registered nurse (RN)-B was interviewed and stated when she observed R3 earlier in the morning, R3 was not wearing the pressure relieving boot and RN-B did not apply the boot. RN-B stated there was no order in R3's treatment administration record (TAR) to apply the boot during the day shift. RN-B confirmed the provider order instructed staff to apply the off-loading boot to R3's left foot anytime when in bed. RN-B stated the wound data assessment should be completed daily even if the resident's wound does not have a dressing change that day. The wound data assessment includes information about how the wound looks, drainage, measurements, and dressing information. RN-B stated she would not know whether the wound was healing or deteriorating, or the provider needed to be updated if the wound data assessment was not completed. RN-B would look at the user-defined assessments (UDA) list to know if an assessment needed to be completed during her shift. On 2/25/2025 at 3:05 p.m., nurse manager (NM)-A was interviewed and stated a wound data collection assessment should be completed with every dressing change or daily if the dressing change is two times a day. The RN wound assessment should be completed once a week by a registered nurse. A nurse would know to complete these assessments by looking at the UDA list. A nurse should be looking at this list every shift and completing the assessments	F 686	the Wound Data Collection UDA daily monitoring. This is required at least weekly when skin integrity is impaired or the open area is present (i.e., pressure ulcer, surgical wound, venous ulcer) and is required to be used daily and with every treatment for documenting observations of skilled service for Medicare or other third-party payer s reimbursement. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. To ensure compliance the DNS/designee will conduct weekly seven (7) random residents skin audits. Audit results will be reviewed by the monthly QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. 5. The date that each deficiency will be corrected. 03/27/2025	

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F 686	Continued From page 3 scheduled for the day. An assessment will remain on the UDA list until it is completed, turning red if it was not completed on the scheduled shift. On 2/26/25 at 10:24 a.m., family member (FM)-A was interviewed and stated when she was visiting R3 the previous evening, R3 was lying in bed without the off-loading boot on. FM-A stated she did not think R3 had the ability to put the boot on or take it off by herself. On 2/26/2025 at 11:06 a.m., R3 was observed laying in her bed on her left side with right foot resting on top of her left foot. A blue, fabric boot with Velcro straps was visualized on a chair near the foot of the bed. She is wearing only socks on her feet. R3 was interviewed and stated she should have a soft blue boot on her foot but does not have it on. Sometimes she wears it in bed and other times she does not. R3 stated she cannot put the boot on by herself and would let the staff put the boot on if they offered. On 2/26/25 at 11:34 a.m., nursing assistant (NA)-C confirmed R3 was lying in bed wearing only socks on her feet. NA-C stated R3 should be wearing the black surgical shoe on her right foot while in bed, not the soft blue boot. On 2/26/2025 at 11:42 a.m., NA-D was interviewed and stated there was no information in the nursing assistant documentation for day shift or on R3's Kardex (a shortened version of the resident care plan utilized by nursing assistants) about wearing an off-loading boot on her left foot while in bed. NA-D stated nursing assistants should be looking at the Kardex before each shift.	F 686		

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F 686	Continued From page 4 On 2/26/25 at 11:56 a.m., R3 was observed sitting in her wheelchair in the dining room wearing a black hard bottom shoe with Velcro on her right foot and a regular shoe on her left foot. NA-E was interviewed and stated R3 was to wear the black "support" shoe on her right foot when she was up and when she laid down for naps during the day but not at night. NA-E confirmed the black hard bottom shoe R3 was wearing was the support shoe. On 2/26/25 at 1:17 p.m., nurse practitioner (NP) was interviewed and stated R3 was to wear a pressure reducing boot on her left foot whenever she is in bed to aid in healing of the pressure ulcer on her left ankle and a surgical shoe with toe protector on her right foot whenever she is out of bed. NP also stated wounds should be monitored and documented on with every dressing change. The documentation is needed to verify the wound is healing. Risks of not following provider orders or not monitoring the wound include worsening of the wound or development of a new wound. On 2/27/25 at 11:50 a.m., the director of nursing (DON) was interviewed and stated a wound data collection assessment should be completed daily for pressure, stasis, and surgical wounds and contains information about the wound, skin around the wound, measurements, and dressing. The assessment should be completed daily. If there is no dressing change scheduled, the assessment can be completed by indicating if the dressing is intact and if any drainage is seen on the outside of the dressing. Measurement of the wound should occur every 7 days and is usually completed during in-house wound rounds or on resident bath day. The RN wound assessment	F 686		

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F 686	Continued From page 5 should be completed weekly. It included an overall assessment of the wound and if the wound is improving or deteriorating. The RN used the assessment to determine if the provider needed to be updated. DON confirmed R3 should have had the wound data assessment completed daily and the RN wound assessment completed weekly, but they had not been completed in the last 2 months. DON stated an off-loading boot is usually a soft, foam boot that is worn when in bed. The boot takes pressure off the heel but allows the resident to reposition themselves easily. R3 should be wearing the boot to protect the pressure ulcer on her ankle and should be wearing it whenever she is in bed. The Wound and Pressure Ulcer Management policy dated 6/05/24 instructed promotion of healing, pain management and prevention of complications are extremely important, as well as accurate assessment and documentation.	F 686		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by:	F 687		3/27/25

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GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

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F 687	Continued From page 6 Based on observation, interview and document review, the facility failed to ensure ongoing, routine toenail care was provided to prevent potential foot-related complications for 1 of 3 residents (R1) reviewed who had long, unkept toenails. Findings include: R1's significant change minimum data set (MDS) dated 2/13/25 indicated intact cognition with diagnoses including multiple sclerosis and bilateral broken legs. R1's care plan dated 1/15/25 indicated R1 required assistance of one staff member for weekly bed baths. The care plan instructed weekly skin observation by licensed nurse and to keep fingernails short but did not address toenail care. R1's medical record was reviewed and lacked information on resident refusal of toenail care and any ongoing monitoring and/or treatments to ensure R1's toenails were cared for timely and on an ongoing basis to reduce her risk of foot-related complications secondary to long toenails. On 2/25/25 at 1:09 p.m., R1 was interviewed and stated staff clip her fingernails, but no one clipped her toenails. Her toenails were long, and they hurt her feet. R1 stated when she asks staff to clip them, she is told that staff will notify the podiatrist, but nothing gets done. On 2/25/25 at 1:16 p.m., registered nurse (RN)-A was interviewed and stated nursing assistants can clip fingernails and toenails unless the resident is diabetic or on a blood thinner, then a	F 687	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident s care plan updated to reflect nail care. Resident R1 nails were trimmed immediately and staff trained to trim nails with every bath day as needed. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents in the facility have the potential to be affected by the deficient practice. As a result, the facility audited all residents toenails to ensure they re all trimmed and clean. Also, nursing staff were educated to ensure that toenails are trimmed per schedule. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. To ensure systemic changes are sustained, all nursing staff have been educated on the GSS policy GSS/Sanford Policy - Activities of Daily Living- R/S, LTC by the DNS/designee. Education content includes but is not limited to - On resident bath/shower day, CNAs should assist residents with nail care of hands and feet. Note: Nail care for a resident who is diabetic or on a blood thinner should be completed by a licensed nurse or podiatrist. Residents whose toenails are unable to be trimmed by a licensed nurse should be referred to podiatry services arranged by the facility.	

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F 687	Continued From page 7 nurse needed to clip the nails. RN-A confirmed R1 was not a diabetic and was not taking blood thinners. RN-A stated there was not specific place in the electronic medical record (EMR) to document nails were clipped, but the nurse could write a nurses note. RN-A confirmed there were no recent nursing notes about R1's toenails being clipped or refusal of toenail trimming. On 2/25/25 at 2:02 p.m., nursing assistant (NA)-A was interviewed and stated clipping a resident's fingernails and toenails should be completed on bath day as needed. A nurse is required to clip the nails of a resident who is a diabetic, but a nursing assistant can clip the nails of all other residents. A nursing assistant could look at a resident's meal ticket to see if they were a diabetic or could ask a nurse. NA-A stated she did not know if there was a place in the EMR to document nail care. On 2/25/25 at 2:14 p.m., NA-B was interviewed and stated nursing assistants should complete nail on bath days for residents who are not diabetic. NA-B also stated she would look at a resident's meal ticket to see if they were a diabetic or could ask a nurse because the information was not on the Kardex (a shortened version of the resident care plan utilized by nursing assistants). NA-B confirmed there was nowhere for a nursing assistant to document nail care in the EMR. On 2/25/25 at 2:52 p.m., a health information management (HIM) specialist was interviewed and stated she kept the list of residents who were seen by in-house podiatry. She confirmed R1 was on the list of people to be seen by the podiatrist, but there was no date set yet for when the	F 687	4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. To ensure compliance the DNS/designee will conduct weekly seven (7) random resident audits. Audit results will be brought to the monthly QAPI committee to input on the need to increase or decrease to ensure substantial compliance is achieved. 5. The date that each deficiency will be corrected. 03/27/2025	

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F 687	Continued From page 8 podiatrist would be at the facility. On 2/25/25 at 3:05 p.m., RN nurse manager (NM)-A was interviewed and stated nail care should be provided to residents on bath days. If nursing staff are unable to clip the resident's toenails, the nurse manager should be notified so an order to see podiatry can be obtained from the provider. A nurse could document nail care in the free text box of the skin assessment. If a resident refuses nail care, it should be documented in a nurse's note. NM-A confirmed R1 was not a diabetic, so the nursing assistants were allowed to trim her nails. On 2/25/25 at 3:40 p.m., R1 was observed laying in her bed. The toenails on her left foot were observed to be several millimeters in length and had uneven, jagged edges on the nail. Nail on the great toe is thickened but the nails on the other toes appear normal thickness. NM-A confirmed R1's nails were really long and stated, "looks like we could clip a couple of those nails". On 2/26/25 at 1:17 p.m., nurse practitioner (NP)-A was interviewed and stated nursing staff should complete nail care. If nursing staff are unable to cut the toenails, an order to see podiatry should be obtained. The risks of long toenails include ingrown toenails, increased pain, and nails rubbing on other toes causing a wound. On 2/27/25 at 11:50 a.m., the director of nursing (DON) was interviewed and stated nail care should be completed by nursing assistants on bath days for residents who are not diabetic. Nurses complete skin assessments and nail care for diabetics. DON confirmed there is no place in the EMR to document nail care because it is	F 687		

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F 687	Continued From page 9 expected as part of the bathing process. Resident refusal of any type of care should be documented in a nursing note. The Activities of Daily Living (ADL) policy dated 12/23/24, indicated any resident who is unable to carry out ADLs will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. ADLs include care of hair, hands, face, shaving, applying makeup, skin, nails, and oral care.	F 687		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to perform a comprehensive assessment of falls to include identifying a root cause and also failed to implement appropriate interventions to reduce the risk of falls for 2 of 3 residents (R2 and R4) reviewed for falls. Findings include: R2's quarterly minimum data set (MDS) dated 2/6/25 indicated intact cognition, no falls since the previous assessment and diagnoses included dementia and chronic obstructive pulmonary	F 689	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R4 passed. R2 s care plan was updated with a new fall intervention implemented immediately which included an OT eval and monitoring for changes with gait and mobility. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents in the facility have the	3/27/25

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F 689	Continued From page 10 disease. R2's care plan dated 2/4/25 indicated R2 was at risk for falls related to weakness and shortness of breath with interventions of educate/instruct resident and family on usage of assistive devices added 10/15/23, remind resident not to bend over to pick up dropped items, encourage use of grabber or to ask for assistance added 10/15/23, and ensure resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair added 10/15/23. The care plan also indicated R3 was independent with four wheeled walker for transfers and ambulation. R2's communication note dated 2/21/25 at 8:00 p.m., indicated R2 was found sitting on the floor by his recliner. Resident stated he was getting up from his recliner to go to the bathroom, lost his balance and slid down to the floor. R2 was able to move all extremities, denied pain, and was assisted back to his recliner by two staff and full mechanical lift. Vital signs were stable. Family member was notified, and floor manager and director of nursing (DON) will be updated. On 2/26/25, R2's electronic medical record lacked information about an immediate intervention put in place to prevent a subsequent fall. R4's significant change MDS dated 2/12/25 indicated intact cognition, no falls since the last assessment, and diagnoses included congestive heart failure and type 2 diabetes. R4's care plan dated 2/12/25 indicated R4 had an actual fall related to losing his balance reaching for remote initiated on 10/5/24. Interventions included to:	F 689	potential to be affected by the deficient practice. As a result the facility audited all residents who have had a fall in the last 60 days to ensure care plan had appropriate intervention. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. To ensure systemic changes are sustained all nursing staff have been educated on the GSS policy GSS/Sanford Policy Fall Prevention and Management Rehab/Skilled, Therapy & Rehab by the DNS/designee. Education content includes but not limited to best practices for a fallen resident and proper documentation. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. To ensure compliance the DNS/designee will conduct weekly seven (7) random resident audits. Audit results will be brought to the monthly QAPI committee for input on the need to increase or decrease to ensure substantial compliance is achieved. 5. The date that each deficiency will be corrected. 03/27/2025	

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F 689	Continued From page 11 1) Keep door his open to check on resident as he does not always ask for help when needed added 8/29/24. 2) Educate/instruct resident to ask for assistance from staff when feeling unwell or weak added 10/7/24. 3) Remind R4 not to bend over to pick up dropped items or items out of his reach. The reacher device provided and resident demonstrated use. 4) Encourage use and remind R4 to ask for assistance added 10/7/24. 5) Ensure R4 was wearing appropriate footwear when ambulating or mobilizing in wheelchair added 2/21/24 6) Ensure correct bed height by marking bed frame or wall to top of mattress or headboard added 5/16/24. 7) Review resident's medical record for medications or combinations of medications that could predispose to falls/increase risk added 10/5/24. 8) Review the status of any medical conditions that predispose R4 to falls or that could increase the risk of injury from falls added 5/16/24. The care plan indicated R4 was resistive to care related to dignity evidenced by refusal of assistance with personal/perineal hygiene, transfer assistance, and toileting. R4's communication with provider note dated 2/18/25 indicated R4 was found on his bathroom floor with a skin tear on his left elbow. Nurse practitioner was updated and provided orders to update with any changes and try to keep R4 at the facility due to comfort care status. R4's communication with provider note dated 2/21/25 at 11:18 a.m., indicated consult to	F 689		

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F 689	Continued From page 12	F 689		

hospice agency as soon as possible due to mass obstructing airway.

R4's risk management resident description of event dated 2/17/25 indicated R4 was trying to reach the brief, lost his balance, and fell. Immediate action taken was to put R4 back to bed and remind him to call for help if he wants to get out of bed.

R4's health status note dated 2/21/25 at 1:43 p.m., indicated the interdisciplinary team (IDT) met to discuss resident catheter and fall on 2/17/24, reaching for brief. Interventions listed were remind resident to not reach for items, use call light and ask for help, and reacher device given for resident use. R4's care plan was reviewed and reflected current care needs.

R4's incident note dated 2/24/25 at 12:40 a.m., indicated R4 transferred himself to the bathroom, fell, then used the call light in the bathroom to call for help. R4 was found lying on the floor on his left side. Vital signs were taken. R4 complained of pain in his left hip and could not move his leg. R4 was transferred to his bed and provider and family notified. R4 was sent to the hospital for evaluation.

R4's risk management resident description of event dated 2/24/25 indicated R4 was trying to sit down on the toilet, lost his balance, and fell.

R4's other progress note dated 2/24/25 at 2:04 p.m., indicated R4 had a left hip fracture.

On 2/26/25 at 10:48 a.m., registered nurse (RN)-B stated after a fall, the nurse should complete a risk management and a falls huddle

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F 689	Continued From page 13 worksheet. The falls huddle worksheet has all the information about a fall with a place to draw a picture of how the resident looked when a staff member found them on the floor. The risk management and falls huddle worksheet should be completed before a nurse leaves the facility at the end of their shift. The falls huddle worksheet is given to the nurse manager or slid under the nurse manager's office door if they have left for the day. On 2/26/25 at 1:17 p.m., nurse practitioner (NP)-A stated after a resident falls, nursing home staff should try to figure out why the resident fell. What were they trying to do when they self-transferred? Were they sick or in the hospital recently and had gotten weak? Were they going to the toilet more than usual? An in-depth investigation should be completed on all falls with an intervention put in place that is appropriate to the resident and the fall. NP-A stated some interventions could include therapy assessments and treatment, assessment of how the resident transfers, assisting with toileting at a specific time, and more frequent checks. NP-A stated R4 did his own thing and did not accept much help from staff. On 2/26/25 at 2:41 p.m., nurse manager (NM)-B stated after a resident falls, the nurse should fill out the fall huddle worksheet and risk management including an immediate intervention put in place. The nurse and nurse manager start the fall huddle worksheet. Then it is given to the director of nursing (DON). The interdisciplinary team (IDT) reviews the fall huddle worksheet and risk management to try to figure out why the resident fell. The resident's current care plan and immediate fall intervention are reviewed for relevance. The immediate intervention is added	F 689		

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F 689	Continued From page 14 to the resident care plan or a new intervention unique to the current fall is put in place if IDT determines something else is needed. NM-B stated she had not received the fall huddle worksheet for R2's fall on 2/21/24. On 2/26/25 at 4:46 p.m., RN-C stated after a resident falls, a risk management and a fall huddle worksheet should be completed before the end of the shift. RN-C confirmed she was the nurse working when R2 fell on 2/21/25. RN-C stated her shift was very busy that night and did not have time to fill out the fall huddle worksheet. R2 did not have any injuries from the fall so staff assisted him back into his recliner. RN-C could not recall if an immediate intervention was put in place and confirmed she did not fill out the fall huddle worksheet. On 2/26/25 at 3:38 p.m., the director of nursing (DON) stated there is a falls check list with the falls huddle worksheet. A nurse should follow the check list after a resident fall. The nurse starts the falls huddle worksheet with information about the fall then gives it to the nurse manager who reviews the check list and interventions. The worksheet then goes to the DON and it is reviewed with IDT. IDT meets every Tuesday and reviews the fall note, risk management, and falls huddle worksheet for date and time of fall, what the resident was doing, how they were found, what intervention was put in place and is that intervention in the care plan. IDT reviews falls weekly for one month to monitor if the intervention is effective. A complete root cause investigation included reviewing risk management, fall huddle worksheet, fall risk assessment, previous health status notes and clinical monitoring to see if the resident had a	F 689		

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F 689	Continued From page 15 change of condition. DON confirmed the falls huddle worksheet could not be located for R2's fall on 2/21/25 and there was no immediate intervention listed in the risk management or on R2's care plan. DON stated it was difficult to know what happened without the floor nurse information included in the fall huddle worksheet. DON confirmed the falls huddle worksheets could not be located for R4's falls on 2/17/25 and 2/24/25. DON stated IDT had reviewed R4's fall on 2/17/25 in an IDT meeting on 2/18/25 determined the root cause of the fall was R4 was reaching for his brief but did not know if R4 was reaching to pull up a brief he was wearing or if he was reaching for a clean brief to put on. IDT determined an appropriate intervention was education about utilizing his call light for assistance because R4 was cognitively intact. R4 was sent to the hospital following the fall on 2/24/25 and he returned the same day. R4's care plan had been reviewed to determine the care plan was being followed, but there was no immediate intervention put in place and a root cause investigation had not been started. On 2/26/25 at 4:12 p.m. the administrator stated determining the root cause of a fall would be difficult without the falls huddle worksheet. The Fall Prevention and Management policy dated 7/29/24, defines root cause analysis as a method for identifying the causes of a problem so that the best solutions can be identified and put into place. The policy instructs staff to complete a fall scene huddle worksheet following a resident fall then give the completed worksheet to the fall committee chair or designee and review and update the care plan with any new changes or new interventions.	F 689		

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F 689	Continued From page 16 The Fall Committee Guidelines policy dated 6/17/25, instructs the interdisciplinary team to gather data from the fall huddle, trend fall events, review fall reports in Point Click Care (the electronic medical record) and review care plans and may add, modify or evaluate fall interventions. Root cause analysis data collected at the scene of the fall, analyzed and trended, can provide evidence-based, validated information to drive necessary changes.	F 689		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/25/25 through 2/27/25, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H52347601C (MN00110688) with orders cited at 4658.0520 Subp. 2F and 08604658.0525 Subp. 3. H52348822C (MN00111006) with an order cited at 4658.0520 Subp. 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 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	2 000		

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	00924	A. BUILDING: _____ B. WING _____	C 02/27/2025

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2 000	Continued From page 2 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 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 MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to perform a comprehensive assessment of falls to include identifying a root cause and also failed to implement appropriate interventions to reduce the risk of falls for 2 of 3 residents (R2 and R4) reviewed for falls.	2 830	Corrected	3/27/25

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2 830	Continued From page 3 Findings include: R2's quarterly minimum data set (MDS) dated 2/6/25 indicated intact cognition, no falls since the previous assessment and diagnoses included dementia and chronic obstructive pulmonary disease. R2's care plan dated 2/4/25 indicated R2 was at risk for falls related to weakness and shortness of breath with interventions of educate/instruct resident and family on usage of assistive devices added 10/15/23, remind resident not to bend over to pick up dropped items, encourage use of grabber or to ask for assistance added 10/15/23, and ensure resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair added 10/15/23. The care plan also indicated R3 was independent with four wheeled walker for transfers and ambulation. R2's communication note dated 2/21/25 at 8:00 p.m., indicated R2 was found sitting on the floor by his recliner. Resident stated he was getting up from his recliner to go to the bathroom, lost his balance and slid down to the floor. R2 was able to move all extremities, denied pain, and was assisted back to his recliner by two staff and full mechanical lift. Vital signs were stable. Family member was notified, and floor manager and director of nursing (DON) will be updated. On 2/26/25, R2's electronic medical record lacked information about an immediate intervention put in place to prevent a subsequent fall. R4's significant change MDS dated 2/12/25 indicated intact cognition, no falls since the last assessment, and diagnoses included congestive	2 830		

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2 830	Continued From page 4 heart failure and type 2 diabetes. R4's care plan dated 2/12/25 indicated R4 had an actual fall related to losing his balance reaching for remote initiated on 10/5/24. Interventions included to: 1) Keep door his open to check on resident as he does not always ask for help when needed added 8/29/24. 2) Educate/instruct resident to ask for assistance from staff when feeling unwell or weak added 10/7/24. 3) Remind R4 not to bend over to pick up dropped items or items out of his reach. The reacher device provided and resident demonstrated use. 4) Encourage use and remind R4 to ask for assistance added 10/7/24. 5) Ensure R4 was wearing appropriate footwear when ambulating or mobilizing in wheelchair added 2/21/24 6) Ensure correct bed height by marking bed frame or wall to top of mattress or headboard added 5/16/24. 7) Review resident's medical record for medications or combinations of medications that could predispose to falls/increase risk added 10/5/24. 8) Review the status of any medical conditions that predispose R4 to falls or that could increase the risk of injury from falls added 5/16/24. The care plan indicated R4 was resistive to care related to dignity evidenced by refusal of assistance with personal/perineal hygiene, transfer assistance, and toileting. R4's communication with provider note dated 2/18/25 indicated R4 was found on his bathroom floor with a skin tear on his left elbow. Nurse practitioner was updated and provided orders to	2 830		

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2 830	Continued From page 5 update with any changes and try to keep R4 at the facility due to comfort care status. R4's communication with provider note dated 2/21/25 at 11:18 a.m., indicated consult to hospice agency as soon as possible due to mass obstructing airway. R4's risk management resident description of event dated 2/17/25 indicated R4 was trying to reach the brief, lost his balance, and fell. Immediate action taken was to put R4 back to bed and remind him to call for help if he wants to get out of bed. R4's health status note dated 2/21/25 at 1:43 p.m., indicated the interdisciplinary team (IDT) met to discuss resident catheter and fall on 2/17/24, reaching for brief. Interventions listed were remind resident to not reach for items, use call light and ask for help, and reacher device given for resident use. R4's care plan was reviewed and reflected current care needs. R4's incident note dated 2/24/25 at 12:40 a.m., indicated R4 transferred himself to the bathroom, fell, then used the call light in the bathroom to call for help. R4 was found lying on the floor on his left side. Vital signs were taken. R4 complained of pain in his left hip and could not move his leg. R4 was transferred to his bed and provider and family notified. R4 was sent to the hospital for evaluation. R4's risk management resident description of event dated 2/24/25 indicated R4 was trying to sit down on the toilet, lost his balance, and fell. R4's other progress note dated 2/24/25 at 2:04 p.m., indicated R4 had a left hip fracture.	2 830		

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2 830	Continued From page 6 On 2/26/25 at 10:48 a.m., registered nurse (RN)-B stated after a fall, the nurse should complete a risk management and a falls huddle worksheet. The falls huddle worksheet has all the information about a fall with a place to draw a picture of how the resident looked when a staff member found them on the floor. The risk management and falls huddle worksheet should be completed before a nurse leaves the facility at the end of their shift. The falls huddle worksheet is given to the nurse manager or slid under the nurse manager's office door if they have left for the day. On 2/26/25 at 1:17 p.m., nurse practitioner (NP)-A stated after a resident falls, nursing home staff should try to figure out why the resident fell. What were they trying to do when they self-transferred? Were they sick or in the hospital recently and had gotten weak? Were they going to the toilet more than usual? An in-depth investigation should be completed on all falls with an intervention put in place that is appropriate to the resident and the fall. NP-A stated some interventions could include therapy assessments and treatment, assessment of how the resident transfers, assisting with toileting at a specific time, and more frequent checks. NP-A stated R4 did his own thing and did not accept much help from staff. On 2/26/25 at 2:41 p.m., nurse manager (NM)-B stated after a resident falls, the nurse should fill out the fall huddle worksheet and risk management including an immediate intervention put in place. The nurse and nurse manager start the fall huddle worksheet. Then it is given to the director of nursing (DON). The interdisciplinary team (IDT) reviews the fall huddle worksheet and risk management to try to figure out why the	2 830		

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2 830	Continued From page 7 resident fell. The resident's current care plan and immediate fall intervention are reviewed for relevance. The immediate intervention is added to the resident care plan or a new intervention unique to the current fall is put in place if IDT determines something else is needed. NM-B stated she had not received the fall huddle worksheet for R2's fall on 2/21/24. On 2/26/25 at 4:46 p.m., RN-C stated after a resident falls, a risk management and a fall huddle worksheet should be completed before the end of the shift. RN-C confirmed she was the nurse working when R2 fell on 2/21/25. RN-C stated her shift was very busy that night and did not have time to fill out the fall huddle worksheet. R2 did not have any injuries from the fall so staff assisted him back into his recliner. RN-C could not recall if an immediate intervention was put in place and confirmed she did not fill out the fall huddle worksheet. On 2/26/25 at 3:38 p.m., the director of nursing (DON) stated there is a falls check list with the falls huddle worksheet. A nurse should follow the check list after a resident fall. The nurse starts the falls huddle worksheet with information about the fall then gives it to the nurse manager who reviews the check list and interventions. The worksheet then goes to the DON and it is reviewed with IDT. IDT meets every Tuesday and reviews the fall note, risk management, and falls huddle worksheet for date and time of fall, what the resident was doing, how they were found, what intervention was put in place and is that intervention in the care plan. IDT reviews falls weekly for one month to monitor if the intervention is effective. A complete root cause investigation included reviewing risk management, fall huddle worksheet, fall risk	2 830		

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2 830	Continued From page 8 assessment, previous health status notes and clinical monitoring to see if the resident had a change of condition. DON confirmed the falls huddle worksheet could not be located for R2's fall on 2/21/25 and there was no immediate intervention listed in the risk management or on R2's care plan. DON stated it was difficult to know what happened without the floor nurse information included in the fall huddle worksheet. DON confirmed the falls huddle worksheets could not be located for R4's falls on 2/17/25 and 2/24/25. DON stated IDT had reviewed R4's fall on 2/17/25 in an IDT meeting on 2/18/25 determined the root cause of the fall was R4 was reaching for his brief but did not know if R4 was reaching to pull up a brief he was wearing or if he was reaching for a clean brief to put on. IDT determined an appropriate intervention was education about utilizing his call light for assistance because R4 was cognitively intact. R4 was sent to the hospital following the fall on 2/24/25 and he returned the same day. R4's care plan had been reviewed to determine the care plan was being followed, but there was no immediate intervention put in place and a root cause investigation had not been started. On 2/26/25 at 4:12 p.m. the administrator stated determining the root cause of a fall would be difficult without the falls huddle worksheet. The Fall Prevention and Management policy dated 7/29/24, defines root cause analysis as a method for identifying the causes of a problem so that the best solutions can be identified and put into place. The policy instructs staff to complete a fall scene huddle worksheet following a resident fall then give the completed worksheet to the fall committee chair or designee and review and update the care plan with any new changes or	2 830		

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2 830	Continued From page 9 new interventions. The Fall Committee Guidelines policy dated 6/17/25, instructs the interdisciplinary team to gather data from the fall huddle, trend fall events, review fall reports in Point Click Care (the electronic medical record) and review care plans and may add, modify or evaluate fall interventions. Root cause analysis data collected at the scene of the fall, analyzed and trended, can provide evidence-based, validated information to drive necessary changes. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and implement measures to ensure appropriate supervision and analaysis of falls occurs for fall prevention. The director of nursing or designee, should conduct measurable audits of fall to ensure analysis of the root cause if completed and identify if appropriate interventions are in place to prevent falls. The DON or designee should educate staff to those intervention. The results of audits should be taken to QAPI to determine compliance or the need for ongoing monitoring. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	2 830		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and	2 860		3/27/25

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2 860	Continued From page 10 trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure ongoing, routine toenail care was provided to prevent potential foot-related complications for 1 of 3 residents (R1) reviewed who had long, unkept toenails. Findings include: R1's significant change minimum data set (MDS) dated 2/13/25 indicated intact cognition with diagnoses including multiple sclerosis and bilateral broken legs. R1's care plan dated 1/15/25 indicated R1 required assistance of one staff member for weekly bed baths. The care plan instructed weekly skin observation by licensed nurse and to keep fingernails short but did not address toenail care. R1's medical record was reviewed and lacked information on resident refusal of toenail care and any ongoing monitoring and/or treatments to ensure R1's toenails were cared for timely and on an ongoing basis to reduce her risk of foot-related complications secondary to long toenails. On 2/25/25 at 1:09 p.m., R1 was interviewed and stated staff clip her fingernails, but no one clipped her toenails. Her toenails were long, and they hurt her feet. R1 stated when she asks staff to clip them, she is told that staff will notify the podiatrist, but nothing gets done.	2 860	Corrected	

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2 860	Continued From page 11 On 2/25/25 at 1:16 p.m., registered nurse (RN)-A was interviewed and stated nursing assistants can clip fingernails and toenails unless the resident is diabetic or on a blood thinner, then a nurse needed to clip the nails. RN-A confirmed R1 was not a diabetic and was not taking blood thinners. RN-A stated there was not specific place in the electronic medical record (EMR) to document nails were clipped, but the nurse could write a nurses note. RN-A confirmed there were no recent nursing notes about R1's toenails being clipped or refusal of toenail trimming. On 2/25/25 at 2:02 p.m., nursing assistant (NA)-A was interviewed and stated clipping a resident's fingernails and toenails should be completed on bath day as needed. A nurse is required to clip the nails of a resident who is a diabetic, but a nursing assistant can clip the nails of all other residents. A nursing assistant could look at a resident's meal ticket to see if they were a diabetic or could ask a nurse. NA-A stated she did not know if there was a place in the EMR to document nail care. On 2/25/25 at 2:14 p.m., NA-B was interviewed and stated nursing assistants should complete nail on bath days for residents who are not diabetic. NA-B also stated she would look at a resident's meal ticket to see if they were a diabetic or could ask a nurse because the information was not on the Kardex (a shortened version of the resident care plan utilized by nursing assistants). NA-B confirmed there was nowhere for a nursing assistant to document nail care in the EMR. On 2/25/25 at 2:52 p.m., a health information management (HIM) specialist was interviewed and stated she kept the list of residents who were	2 860		

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2 860	Continued From page 12 seen by in-house podiatry. She confirmed R1 was on the list of people to be seen by the podiatrist, but there was no date set yet for when the podiatrist would be at the facility. On 2/25/25 at 3:05 p.m., RN nurse manager (NM)-A was interviewed and stated nail care should be provided to residents on bath days. If nursing staff are unable to clip the resident's toenails, the nurse manager should be notified so an order to see podiatry can be obtained from the provider. A nurse could document nail care in the free text box of the skin assessment. If a resident refuses nail care, it should be documented in a nurse's note. NM-A confirmed R1 was not a diabetic, so the nursing assistants were allowed to trim her nails. On 2/25/25 at 3:40 p.m., R1 was observed laying in her bed. The toenails on her left foot were observed to be several millimeters in length and had uneven, jagged edges on the nail. Nail on the great toe is thickened but the nails on the other toes appear normal thickness. NM-A confirmed R1's nails were really long and stated, "looks like we could clip a couple of those nails". On 2/26/25 at 1:17 p.m., nurse practitioner (NP)-A was interviewed and stated nursing staff should complete nail care. If nursing staff are unable to cut the toenails, an order to see podiatry should be obtained. The risks of long toenails include ingrown toenails, increased pain, and nails rubbing on other toes causing a wound. On 2/27/25 at 11:50 a.m., the director of nursing (DON) was interviewed and stated nail care should be completed by nursing assistants on bath days for residents who are not diabetic. Nurses complete skin assessments and nail care	2 860		

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2 860	Continued From page 13 for diabetics. DON confirmed there is no place in the EMR to document nail care because it is expected as part of the bathing process. Resident refusal of any type of care should be documented in a nursing note. The Activities of Daily Living (ADL) policy dated 12/23/24, indicated any resident who is unable to carry out ADLs will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. ADLs include care of hair, hands, face, shaving, applying makeup, skin, nails, and oral care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents requiring assistnace with foot care or referral for diabetic foot care and educate staff to cares. 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 of complications associated from lack of appropriate foot care. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director	2 900		3/27/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 14 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 MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess wounds with measurements and consistently implement interventions to promote healing of current pressure ulcers (PU) for 1 of 3 residents (R3). Findings include: R3's quarterly minimum data set dated 2/13/25 indicated severe cognitive impairment, required substantial assistance with footwear, had one unhealed Stage 3 PU (full thickness loss of skin) and at risk for developing more, and did not exhibit rejection of care behaviors. R3's care plan dated 2/10/25, indicated R3 had a Stage 3 pressure ulcer to her left lateral (outer side) ankle with interventions included provide pressure reducing mattress and pressure reducing cushion in wheelchair, notify nurse immediately of any new areas of skin breakdown,	2 900	Corrected	

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	00924	A. BUILDING: _____ B. WING _____	C 02/27/2025

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2 900	Continued From page 15 R3 had an activities of daily living (ADL) performance deficit with interventions included resident requires assistance of one staff apply surgical shoe on right foot and shoe on left foot. R3's care plan lacks information about an off-loading boot to her left foot while she is in bed. R3's physician orders summary dated 2/26/24, instructed staff to apply heel boot to left foot at night and anytime when in bed during the day. Okay to remove when sitting in wheelchair. An additional provider order instructed wear a surgical shoe to right foot. R3's physician order summary also included an order to change dressing to left lateral ankle wound every other day. On 2/26/25 at 10:48 a.m., registered nurse (RN)-B was interviewed and stated when she observed R3 earlier in the morning, R3 was not wearing the pressure relieving boot and RN-B did not apply the boot. RN-B stated there was no order in R3's treatment administration record (TAR) to apply the boot during the day shift. RN-B confirmed the provider order instructed staff to apply the off-loading boot to R3's left foot anytime when in bed. RN-B stated the wound data assessment should be completed daily even if the resident's wound does not have a dressing change that day. The wound data assessment includes information about how the wound looks, drainage, measurements, and dressing information. RN-B stated she would not know whether the wound was healing or deteriorating, or the provider needed to be updated if the wound data assessment was not completed. RN-B would look at the user-defined assessments (UDA) list to know if an assessment needed to be completed during her shift.	2 900		

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2 900	Continued From page 16 On 2/25/2025 at 3:05 p.m., nurse manager (NM)-A was interviewed and stated a wound data collection assessment should be completed with every dressing change or daily if the dressing change is two times a day. The RN wound assessment should be completed once a week by a registered nurse. A nurse would know to complete these assessments by looking at the UDA list. A nurse should be looking at this list every shift and completing the assessments scheduled for the day. An assessment will remain on the UDA list until it is completed, turning red if it was not completed on the scheduled shift. On 2/26/25 at 10:24 a.m., family member (FM)-A was interviewed and stated when she was visiting R3 the previous evening, R3 was lying in bed without the off-loading boot on. FM-A stated she did not think R3 had the ability to put the boot on or take it off by herself. On 2/26/2025 at 11:06 a.m., R3 was observed laying in her bed on her left side with right foot resting on top of her left foot. A blue, fabric boot with Velcro straps was visualized on a chair near the foot of the bed. She is wearing only socks on her feet. R3 was interviewed and stated she should have a soft blue boot on her foot but does not have it on. Sometimes she wears it in bed and other times she does not. R3 stated she cannot put the boot on by herself and would let the staff put the boot on if they offered. On 2/26/25 at 11:34 a.m., nursing assistant (NA)-C confirmed R3 was lying in bed wearing only socks on her feet. NA-C stated R3 should be wearing the black surgical shoe on her right foot while in bed, not the soft blue boot. On 2/26/2025 at 11:42 a.m., NA-D was	2 900		

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2 900	Continued From page 17 interviewed and stated there was no information in the nursing assistant documentation for day shift or on R3's Kardex (a shortened version of the resident care plan utilized by nursing assistants) about wearing an off-loading boot on her left foot while in bed. NA-D stated nursing assistants should be looking at the Kardex before each shift. On 2/26/25 at 11:56 a.m., R3 was observed sitting in her wheelchair in the dining room wearing a black hard bottom shoe with Velcro on her right foot and a regular shoe on her left foot. NA-E was interviewed and stated R3 was to wear the black "support" shoe on her right foot when she was up and when she laid down for naps during the day but not at night. NA-E confirmed the black hard bottom shoe R3 was wearing was the support shoe. On 2/26/25 at 1:17 p.m., nurse practitioner (NP) was interviewed and stated R3 was to wear a pressure reducing boot on her left foot whenever she is in bed to aid in healing of the pressure ulcer on her left ankle and a surgical shoe with toe protector on her right foot whenever she is out of bed. NP also stated wounds should be monitored and documented on with every dressing change. The documentation is needed to verify the wound is healing. Risks of not following provider orders or not monitoring the wound include worsening of the wound or development of a new wound. On 2/27/25 at 11:50 a.m., the director of nursing (DON) was interviewed and stated a wound data collection assessment should be completed daily for pressure, stasis, and surgical wounds and contains information about the wound, skin around the wound, measurements, and dressing.	2 900		

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2 900	Continued From page 18 The assessment should be completed daily. If there is no dressing change scheduled, the assessment can be completed by indicating if the dressing is intact and if any drainage is seen on the outside of the dressing. Measurement of the wound should occur every 7 days and is usually completed during in-house wound rounds or on resident bath day. The RN wound assessment should be completed weekly. It included an overall assessment of the wound and if the wound is improving or deteriorating. The RN used the assessment to determine if the provider needed to be updated. DON confirmed R3 should have had the wound data assessment completed daily and the RN wound assessment completed weekly, but they had not been completed in the last 2 months. DON stated an off-loading boot is usually a soft, foam boot that is worn when in bed. The boot takes pressure off the heel but allows the resident to reposition themselves easily. R3 should be wearing the boot to protect the pressure ulcer on her ankle and should be wearing it whenever she is in bed. The Wound and Pressure Ulcer Management policy dated 6/05/24 instructed promotion of healing, pain management and prevention of complications are extremely important, as well as accurate assessment and documentation. 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	2 900		

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2 900	Continued From page 19 potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		