Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 2, 2025

Administrator
REGINA SENIOR LIVING
1175 NININGER ROAD
HASTINGS, MN 55033

RE: CCN: 245254
Cycle Start Date: July 15, 2025

Dear Administrator:

On August 26, 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.

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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Electronically delivered

September 2, 2025

Administrator
REGINA SENIOR LIVING
1175 NININGER ROAD
HASTINGS, MN 55033

Re: Reinspection Results
Event ID: OM3I-H2

Dear Administrator:

On August 26, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 15, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any 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

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 11, 2025

Administrator
REGINA SENIOR LIVING

1175 NININGER ROAD
HASTINGS, MN 55033

RE: CCN: 245254
Cycle Start Date: July 15, 2025

Dear Administrator:

On July 15, 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 26, 2025.
- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 26, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 26, 2025.

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

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by August 26, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Regina Senior Living will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 26, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

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

DEPARTMENT CONTACT

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

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 15, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://

dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the

specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

An equal opportunity employer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	**1175 NININGER ROAD , 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 7/15/25, 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 complaint was reviewed: H52548171C (MN00114200) with deficiencies issued at F553, F656, F684, and F691. 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		08/20/2025
F0553 SS = D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items	F0553	Care Conference for R1 held with full interdisciplinary team to review care plan and treatment goals on 07/16/2025. · All facility residents were reviewed to ensure Care Conferences were up to date and/or scheduled. · Social Work Designee received education regarding coordinating and scheduling care conferences in a timely manner; while meeting requirements of resident participation in care planning . · Social Work Designee will audit care conferences weekly for completion of those that are required based off the quarterly schedule; for 6 weeks. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	08/20/2025

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 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: **245254**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	**1175 NININGER ROAD , HASTINGS, Minnesota, 55033**

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F0553 SS = D	Continued from page 1 included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to offer a care conference during 1 of 3 residents (R1) reviewed for ostomy care. This resulted in R1's inability to participate in his care planning. Findings include: R1's care plan, dated 6/6/25, indicated he required assist of one staff for personal cares. The care plan lacked individualized care for R1's colostomy, as it did not specify the supplies requires or the process to complete the colostomy care. R1's medication administration record (MAR), dated June and July 2025, directed to change ostomy bag two times weekly and as needed for leakage, on Monday and Wednesday evenings. R1's admission Minimum Data Set, dated 6/11/25, indicated R1 had diagnoses of Crohn's disease (chronic inflammatory bowel disease) and had a colostomy (a surgical procedure that creates an opening in the abdominal wall, bringing a portion of the large intestine to the surface). R1's MDS indicated he was cognitively intact. R1's chart lacked documentation of a care conference. On 7/15/25, at 10:21 a.m., R1 stated he would prefer his colostomy bag be scheduled in the morning. He stated there was only one time that it was changed in the morning. He stated he had never attended a care	F0553		

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F0553 SS = D	Continued from page 2 conference in the 5 ½ weeks had been at the facility. R1 stated he had several episodes of his colostomy leaking in the first 20 days at the facility. R1 stated he repeatedly asked the facility to use the products he was familiar with, including rings (intended to create a secure and comfortable seal between an ostomy pouch and the skin around the stoma, to prevent leakage) and wings (small flexible pieces of hydrocolloid adhesive that attach to the edges of an ostomy skin barrier to provide extra security and prevent leaks). R1 stated the facility started providing the requested supplies on 6/25/25. R1 stated his colostomy has had fewer incidents of leaking since the facility has provided the supplies he needed. On 7/15/25, at 1:32 p.m., licensed practical nurse (LPN)-A stated there was not a care conference documented in R1's chart. On 7/15/25, at 3:01 p.m., the director of nursing (DON) stated she was not aware if R1 had a care conference. A facility document, Comprehensive Assessments and Care Planning, dated 2017, directed the residents and resident representatives will be involved in the comprehensive person-centered care planning. If participation of resident and representative in development of plan not practicable explanation must be in resident's medical record. A facility document, Resident Rights and Notification of Resident Rights, 2017 directed Resident Rights include: Planning and Implementing Care.	F0553		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F0656	· Physician orders for colostomy cares clarified for R1. Care plan for R1 was updated to include individualized approaches for colostomy cares. · All facility residents with colostomy orders reviewed and care plans updated accordingly to include individualized approaches. · Nursing staff received education regarding colostomy cares, initiating and adjusting resident care plans, and colostomy order entry. · Colostomy cares will be audited weekly for 6 weeks to ensure proper order entry and care delivered. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if	08/20/2025

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F0656 SS = D	Continued from page 3 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to develop and implement a comprehensive, individualized care plan for 1 of 3 residents (R1) reviewed for ostomy care. The facility failed to have a process in place to instruct staff on physician ordered ostomy care. This resulted in R1's colostomy bag leaking on multiple occasions and emotional distress for R1. Findings include: R1's care plan, dated 6/6/25, indicated he required assist of one staff for personal cares. The care plan lacked individualized care for R1's colostomy, as it did not specify the supplies requires or the process to	F0656	Continued from page 3 substantial compliance is not met.	

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F0656 SS = D	Continued from page 4 complete the colostomy care. R1’s medication administration record (MAR), dated June and July 2025, directed to change ostomy bag two times weekly and as needed for leakage, on Monday and Wednesday evenings. R1’s bowel assessment, dated 6/8/25, failed to appropriately assess his ostomy site with measurements and description. R1’s admission Minimum Data Set, dated 6/11/25, indicated R1 had diagnoses of Crohn’s disease (chronic inflammatory bowel disease) and had a colostomy (a surgical procedure that creates an opening in the abdominal wall, bringing a portion of the large intestine to the surface). R1’s MDS indicated he was cognitively intact. A progress note, on 6/11/25, indicated colostomy bag was changed. Hollister brand used and cut to measure to size of stoma. Skin surrounding stoma is clean, intact and free of breakdown/maceration. No redness, foul odor or signs/symptoms of infection. A progress note, on 6/25/25, indicated colostomy bag and appliance changed. Area is red and macerated around appliance. Skin barrier applied. Patient denies pain but voices that this is not typical appliance he uses at home. Facility will order device familiar to patient. A progress note, on 6/25/25, indicated R1 was up the majority of the night dealing with his colostomy bag. R1 was in clear emotional distress. He reported to writer that he is "traumatized and devastated" and began to become tearful stating he got no sleep. The progress note indicated he was very upset and stated, “I should just put a shotgun to my head” and making comments he did not want to be alive anymore. On 7/15/25, at 10:21 a.m., R1 stated he had several episodes of his colostomy leaking in the first 20 days at the facility. R1 stated he repeatedly asked the facility to use the products he was familiar with, including rings (intended to create a secure and comfortable seal between an ostomy pouch and the skin around the stoma, to prevent leakage) and wings (small flexible pieces of hydrocolloid adhesive that attach to the edges of an ostomy skin barrier to provide extra security and prevent leaks). R1 stated the facility started providing the requested supplies, after he became suicidal due to lack of sleep, from the colostomy leaking four times on 6/25/25. R1 stated his	F0656		

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F0656 SS = D	Continued from page 5 colostomy has had fewer incidents of leaking since the facility has provided the supplies he needed. On 7/15/25, at 1:14 p.m., licensed practical nurse (LPN)-B stated R1's colostomy bag changes required the use of skin prep (creates a protective barrier) and the supplies located in his room. She stated the orders in his chart indicated frequency of scheduled colostomy changes. On 7/15/25, at 1:32 p.m., LPN-A stated the facility did not have the exact supplies R1 wanted for his colostomy, as the facility had formulary colostomy supplies. She stated he was experiencing more incidents of leaking during his first few weeks at the facility. She stated she obtained the required products after he was sent to the hospital on 6/25/25. She stated R1 taught the staff how to perform the colostomy bag changes. She stated two other products were tried for him prior to using the supplies he was prescribed. She stated the supplies for each resident were placed in their rooms. She stated the care plan did not list the process or specific supplies required. She stated she expected the nurses would know how to change the colostomy bags. LPN-A stated the HUC should have listed all the steps ordered by the physician for the colostomy care in the orders for R1. On 7/15/25, at 2:28 p.m., registered nurse (RN)-B stated the facility obtained R1's correct colostomy supplies after he went to the hospital on 6/25/25. RN-B stated the colostomy supplies were located in the residents' rooms. She stated, "There is not anything in the care plan for the step-by-step process or the specific products required." RN-B stated she had changed R1's colostomy on one occasion. She stated she could not confirm if the physician order was followed at that time. She stated she had not seen the order. On 7/15/25, at 3:01 p.m., the director of nursing (DON) stated, "the order is part of the care plan." The DON also stated, "the order feeds the MAR." She stated the facility was using formulary colostomy supplies. She stated there was not an order from the physician to use the facility's formulary colostomy supplies or change the physician ordered process. A facility document, Comprehensive Assessments and Care Planning, dated 2017, directed the facility must make a	F0656		

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NAME OF PROVIDER OR SUPPLIER: **REGINA SENIOR LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE: **1175 NININGER ROAD , HASTINGS, Minnesota, 55033**		

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F0656 SS = D	Continued from page 6 comprehensive assessment of the resident's needs. Baseline care plans address at a minimum, the following: physician orders. The assessment must include at least the following: Continence and Special treatment and procedures. A facility should use the results of the assessment to develop, review and revise the resident's person-centered comprehensive care plan. All person-centered care plan interventions will be implemented by qualified personnel. Interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication.	F0656		
F0684 SS = G	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 interview and document review, the facility failed to assess and evaluate the appropriateness of the colostomy care supplies and ensure proper fitting of the wafer to prevent leakages and failed to provide physician-ordered care for colostomy care for one resident (R1). This failure caused psychosocial harm to R1 when his colostomy care was delayed, and he suffered emotional distress and suicidal ideation. Findings include: On 7/15/25, at 10:21 a.m., R1 stated he had several episodes of his colostomy leaking in the first few weeks at the facility. R1 stated he repeatedly asked the facility to use the products he was familiar with, including rings (intended to create a secure and comfortable seal between an ostomy pouch and the skin around the stoma, to prevent leakage) and wings (small flexible pieces of hydrocolloid adhesive that attach to the edges of an ostomy skin barrier to provide extra security and prevent leaks). R1 stated the facility started providing the requested supplies, after he became suicidal due to lack of sleep, from the colostomy leaking four times on 6/25/25. R1 stated the	F0684	· R1 was assessed for appropriateness of colostomy care supplies, proper fitting of the wafer, and physician-ordered cares. Physician orders and care plan updated accordingly. · Updated PHQ 2-9 was completed on R1 and primary physician completed assessment to determine resident's emotional status. Psychosocial care plan was updated to reflect findings . · All facility residents with colostomies were assessed for appropriateness of colostomy care supplies, proper fitting of the wafer, and physician-ordered cares. Physician orders and care plan updated accordingly. · Updated PHQ 2-9 was completed on all facility residents and physician was notified of any high-risk assessment results to determine need for additional care. Psychosocial care plans were updated to reflect findings. · Nursing staff received education regarding colostomy cares and colostomy order entry. Nursing managers received education on initiating and adjusting resident care plans. · Wound Nurse educated on supply ordering process to include colostomy care supplies as physician-ordered. · Social Services Designee educated on facility policy related to suicidal threats by a resident and psychosocial and emotional distress. · Colostomy cares will be audited weekly for 6 weeks to ensure proper completion of cares per the physician-ordered process. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	08/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245254	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0684 SS = G	Continued from page 7 colostomy leaked stool on the bed, on the floor and on himself. He stated this made him feel “filthy,” “dramatic,” “depressed”, and “dirty”. He stated it made it harder to socialize because he was afraid it would leak. R1 stated his colostomy has had fewer incidents of leaking since the facility has provided the supplies he needed. R1’s hospital record dated 6/1/25 to 6/5/25 indicated R1 was brought by ambulance because of a fall related to weakness, lack of sleep due to burning around his leaking colostomy bag. R1 had problems with ostomy leakage and the hospital would facilitate the necessary ostomy supplies. R1 was discharged on 6/5/25 in stable condition. R1’s hospital discharge orders and instructions dated 6/5/25 instructed the facility to care for R1’s ostomy. Procedure for pouch change: 1) Prepare new pouch, using a Coloplast 16716 or your normal pouches. Opening should be 1/16"- 1/8" larger than the stoma. Set pouch aside. 2) Remove old pouch, and discard. 3) Cleanse peristomal area with warm water only and Versalon 4 x 4's (#118746). *Do not use soap, wipes, adhesive remover, or skin prep to cleanse peristomal skin. 4) Allow skin to dry. At this point - CRUST the peristomal skin 1x. See below for crusting steps. 5) Apply Adapt barrier ring (#116786) and then apply new pouch. 6) Press down firmly all-around stoma and have patient place hand over pouch for 2-3 minutes to enhance seal. 7) Change pouch two times week or immediately if there is a leak. Procedure for crusting: 1. Clean skin gently with warm water and gauze, paper towel or soft wash cloth 2. Sprinkle a layer of ostomy powder over area to be treated-red, irritated, weeping skin surrounding stoma. Gently brush off excess powder using a 4x4 gauze,	F0684	Continued from page 7 * PHQ 2-9 assessments will be audited weekly for 6 weeks to ensure proper follow-up and/or treatment plans are in place for residents experiencing emotional or psychosocial distress. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	

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F0684 SS = G	Continued from page 8 tissue, or your finger. You want a thin layer of powder completely covering the moist area. 3. Blot/pat or spray Cavilon No Sting Barrier Film over powder. Allow barrier film to dry. If an area is missed, allow the entire area to dry first, then go back and spray or blot the area that was missed. 4. Reapply with pouch change until redness clears up. Do not do this procedure if your skin is clear and intact. If your skin worsens or does not heal, please contact your ostomy nurse as you may need a stronger treatment. R1's nurse note, dated 6/5/25, indicated he was admitted to the facility from the hospital after a fall and weakness. It also indicated the skin around his colostomy was irritated and painful. R1 had reported he fell off the toilet from weakness due to lack of sleep from his colostomy bag leaking for 4 days. R1's care plan, dated 6/6/25, indicated he required assist of one staff for personal cares. The care plan lacked individualized care for R1's colostomy, as it did not specify the supplies requires or the process to complete the colostomy care. R1's nurse note, dated 6/11/25, indicated his colostomy bag was changed. Hollister brand used and cut to measure to size of stoma. R1's nurses notes indicated his colostomy bag was changed on 6/6/25, 6/11/25, 6/15/25, 6/20/25, 6/23/25, and 6/25/25. No identifying information was noted related to colostomy supplies used, R1's ostomy redness, or leakage. R1's nurse note, dated 6/25/25, indicated R1 was up the majority of the night dealing with his colostomy bag, as it needed to be changed and reinforced multiple times throughout the night. The note indicated at 6:15 a.m. the nurse found R1 picking at it stating it needed to be changed again and was in clear emotional distress. He reported he was traumatized, devastated, and became tearful, stating he did not get sleep. The note indicated at 8:45 a.m. R1 reported his colostomy was leaking again. R1 was very upset with the situation and made the comment, "I should put a shotgun to my head" and making comments he did not want to be alive	F0684		

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F0684 SS = G	Continued from page 9 any longer. R1's nurse note, dated 6/25/25, indicated colostomy bag and appliance were changed that morning. The skin area was red and macerated around the appliance. R1 voiced this was not the typical appliance he used at home and facility would order device familiar to R1. R1's social work progress note, dated 6/26/25, indicated when discussing discharge with R1, R1 told the social worker if he had to discharge to home, he would shoot himself when he got home because he was frustrated from lack of sleep. R1's physician regulatory visit note, dated 7/9/25, indicated R1 continues to have leakage from his ostomy at night such that it interferes with his sleep. R1 told the physician he has not slept well the last couple of nights. R1 was distressed, telling the physician if he goes home with the ostomy leakage, he will consider ending his life. R1 has had his ostomy for approximately six years with very infrequent leakage, never as persistent as it has been while at the facility. R1's Associated Clinical Psychology note, dated 7/11/25, indicated R1 had anxiety surrounding his colostomy leakage, at time being traumatic affecting his sleep and mood. Suicidal ideation was noted after multiple nights of not sleeping becoming increasing depressed. R1 stated he did not have this problem at home because he had the necessary supplies to manage his ostomy care. A physician order, dated 7/9/25, directed facility to consult with an ostomy nurse to review R1's current set up and offer suggestions about decreasing frequency of nighttime leaks, which are very distressing for him. R1's medical record review 7/15/25 did not indicate the facility followed R1's physician order dated 7/9/25 to schedule an ostomy consult. A letter from the facility's medical director, dated, 7/17/25, indicated R1 was admitted to the facility on 6/5/25 following a hospitalization for weakness and fall, following his colostomy bag leaking for several days. During the hospitalization R1 reported frustration with appliance issues in regards to the	F0684		

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F0684 SS = G	Continued from page 10 ostomy bag not obtaining a proper seal. This caused him significant distress. There were documented notes in his clinical record prior to his care at the facility of frustration that mention appliance issues causing sleep disturbance and lack of sleep leading to suicidal ideation, on 8/11/23 and 11/8/24. During his stay at the facility, R1 continued to voice frustration because of appliance leakage and additional supplies were ordered for him. On the evening of 6/24/25 and into the morning of 6/25/25, R1 mentioned to the staff he was very frustrated, confused, and distressed and if he had access to firearms, he would likely shoot himself because of his low quality of life. The pattern predated his stay at the facility. The facility used appropriate and standard ostomy equipment to make every effort to accommodate R1's needs. And R1's historical concerns, including suicidal ideations, were not communicated at the time of his admission to the facility and were not included to his problem list on external records. R1's admission Minimum Data Set, dated 6/11/25, indicated R1 had diagnoses of Crohn's disease (chronic inflammatory bowel disease) and had a colostomy (a surgical procedure that creates an opening in the abdominal wall, bringing a portion of the large intestine to the surface). R1's MDS indicated he was cognitively intact. On 7/15/25, at 1:32 p.m., licensed practical nurse (LPN)-A she was wound and ostomy certified. She verified that she did not assess or evaluate R1's oblong shaped stoma to get the right wafer fit. She stated the facility did not have the exact appropriate supplies R1 wanted for his colostomy. She stated he was experiencing more incidents of leaking during his first few weeks at the facility. She stated she was responsible to order colostomy supplies. She stated she did not put in an order for the Coloplast brand of ostomy supplies for R1. She stated she obtained the required products after R1 was sent to the hospital on 6/25/25. She stated the supplies for each resident were placed in their rooms. She stated the care plan lacked the step-by-step process and the specific supplies required to manage R1's ostomy care. LPN-A acknowledged that when R1's colostomy leaked with bowel movement (BM), it affected him causing suicidal thoughts and was sent to ER, and added "we did not know it was affecting him psychologically." She stated the HUC entered the physician orders for R1 and should have listed all the steps in the process, as they were written. She stated she expected the nurses would know how to change the colostomy bags and did not do much training on ostomies. She stated R1 "taught staff" his (referring	F0684		

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F0684 SS = G	Continued from page 11 to R1) preference. LPN-A stated the appointment with the ostomy clinic, chosen by R1, had not yet been arranged, although it was ordered 6 days prior, on 7/9/25. When questioned about the steps taken from 7/9/25, to ensure proper colostomy care orders and determine the root cause of the leakage, LPN-A did not respond. On 7/15/25, at 2:20pm, RN-A stated, “I do not know if he has the right product” (referring to R1’s colostomy supplies) and R1 “was very worried and was very sensitive about his colostomy.” RN-A also verified that the hospital orders dated 6/5/25 were not followed and stated the care plan did not specify the colostomy product to be used. On 7/15/25, at 3:01 p.m., the director of nursing (DON) stated a physicians provide orders for colostomy care. She stated the health unit coordinator (HUC) enters the orders into the system exactly as they are written by the physician. The DON stated the facility has company formulary colostomy supplies. She stated she was not aware of an order to change the supplies ordered for R1’s colostomy care or a change of orders to change the step-by-step process provided upon his admission to the facility. The DON stated the facility was not ignoring the order written on 7/9/25 to set up an appointment for R1 with an ostomy nurse consultation. She stated he was in the process of discharging. A facility document, Comprehensive Assessments and Care Planning, dated 2017, directed the purpose of the policy was to provide a comprehensive person-centered interdisciplinary care assessment of the resident’s condition, in order to develop consistent quality care that will attain or maintain the highest practicable physical, mental and psychological functioning possible, a facility must make a comprehensive assessment of a resident’s needs, using the resident assessment instrument (RAI) specified by the State. 2)The assessment process begins with the development of the baseline care plan within the first 48 hours of admission. The baseline care plant includes the minimum healthcare information necessary to care for each resident immediately upon their admission, which would address resident-specific health and safety concerns to prevent decline or injury. Baseline care plans address, at a minimum, the following: physician orders. 6) The assessment must include at least the following: j) special treatment and procedures. 11) All person-centered care plan interventions will be implemented by qualified personnel. Interventions may	F0684		

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F0684 SS = G	Continued from page 12 be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication. A facility document, Physician Services, dated 2022, directed all physician orders will be followed as prescribed and if not followed, the reason shall be recorded in the resident's medical record during that shift.	F0684		
F0691 SS = D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R1) reviewed for ostomy care, received colostomy care as ordered by the physician. This resulted in inappropriate care, as evidenced by frequent leakage incidents for R1. Findings include: R1's care plan, dated 6/6/25, indicated he required assist of one staff for personal cares. The care plan lacked individualized care for R1's colostomy, as it did not specify the supplies requires or the process to complete the colostomy care. R1's after discharge orders from the hospital, dated 6/5/25 directed: Procedure for pouch change: 1) Prepare new pouch, using a Coloplast 16716 or your normal pouches. Opening should be 1/16"- 1/8" larger than the stoma. Set pouch aside. 2) Remove old pouch, and discard. 3) Cleanse peristomal area with warm water only and Versalon 4 x 4's (#118746). *Do not use soap, wipes,	F0691	R1 was assessed for appropriateness of colostomy care supplies, proper fitting of the wafer, and physician-ordered cares. Physician orders and care plan updated accordingly. All facility residents with colostomies were assessed for appropriateness of colostomy care supplies, proper fitting of the wafer, and physician-ordered cares. Physician orders and care plan updated accordingly. Nursing staff received education regarding colostomy cares and colostomy order entry. Nursing managers received education on initiating and adjusting resident care plans.Wound Nurse educated on supply ordering process to include colostomy care supplies; as physician-ordered. * Colostomy cares will be audited weekly for 6 weeks to ensure proper completion of cares per the physician-ordered process. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	08/20/2025

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F0691 SS = D	Continued from page 13	F0691		

adhesive remover, or skin prep to cleanse peristomal skin.

4) Allow skin to dry. At this point - CRUST the peristomal skin 1x. See below for crusting steps.

5) Apply Adapt barrier ring (#116786) and then apply new pouch.

6) Press down firmly all-around stoma and have patient place hand over pouch for 2-3 minutes to enhance seal.

7) Change pouch 2x/week or immediately if there is a leak.

Procedure for crusting:

1. Clean skin gently with warm water and gauze, paper towel or soft wash cloth

2. Sprinkle a layer of ostomy powder over area to be treated-red, irritated, weeping skin surrounding stoma. Gently brush off excess powder using a 4x4 gauze, tissue, or your finger. You want a thin layer of powder completely covering the moist area.

3. Blot/pat or spray Cavilon No Sting Barrier Film over powder. Allow barrier film to dry. If an area is missed, allow the entire area to dry first, then go back and spray or blot the area that was missed.

4. Reapply with pouch change until redness clears up. Do not do this procedure if your skin is clear and intact. If your skin worsens or does not heal, please contact your ostomy nurse as you may need a stronger treatment.

R1’s admission Minimum Data Set, dated 6/11/25, indicated R1 had diagnoses of Crohn’s disease (chronic inflammatory bowel disease) and had a colostomy (a surgical procedure that creates an opening in the abdominal wall, bringing a portion of the large intestine to the surface). R1’s MDS indicated he was cognitively intact.

R1’s nurse note, dated 6/11/25, indicated his colostomy bag was changed. Hollister brand used and cut to measure to size of stoma.

R1’s nurses notes indicated his colostomy bag was

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F0691 SS = D	Continued from page 14 changed on 6/6/25, 6/11/25, 6/15/25, 6/20/25, 6/23/25, and 6/25/25. No identifying information was noted related to colostomy supplies used, R1’s ostomy redness, or leakage. R1’s medication administration record (MAR), dated June and July 2025, directed to change ostomy bag two times weekly and as needed for leakage, on Monday and Wednesday evenings. A physician order, dated 7/9/25, directed facility to facility and consult with an ostomy nurse to review R1’s current set up and offer suggestions about decreasing frequency of nighttime leaks, which are very distressing for him. R1’s medical record review 7/15/25 did not indicate the facility followed R1’s physician order dated 7/9/25 to schedule an ostomy consult. On 7/15/25, at 10:21 a.m., R1 stated he had several episodes of his colostomy leaking in the first 20 days at the facility. R1 stated he repeatedly asked the facility to use the products he was familiar with, including rings (intended to create a secure and comfortable seal between an ostomy pouch and the skin around the stoma, to prevent leakage) and wings (small flexible pieces of hydrocolloid adhesive that attach to the edges of an ostomy skin barrier to provide extra security and prevent leaks). R1 stated the facility started providing the requested supplies on 6/25/25. R1 stated his colostomy has had fewer incidents of leaking since the facility has provided the supplies he needed. R1 stated he had not seen an ostomy nurse. On 7/15/25, at 1:14 p.m., licensed practical nurse (LPN)-B stated R1’s colostomy bag changes required the use of skin prep (creates a protective barrier), and the supplies located in his room. She stated orders indicated frequency of scheduled colostomy changes. On 7/15/25, at 1:32 p.m., LPN-A stated the facility did not have the exact supplies R1 wanted for his colostomy. She stated he was experiencing more incidents of leaking during his first 20 days at the facility. LPN-A stated the health unit coordinator entered R1’s orders and should have listed all steps, as the physician wrote them. LPN-B stated	F0691		

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F0691 SS = D	Continued from page 15 she was responsible to order colostomy supplies. She stated she obtained the required products after he was sent to the hospital on 6/25/25. She stated the supplies for each resident were placed in their rooms. She stated the care plan did not list the process or specific supplies required. She stated she expected the nurses would know how to change the colostomy bags. LPN-A stated the appointment with the ostomy clinic, chosen by R1, had not yet been arranged, although it was ordered 6 days prior. She stated the facility was working on discharge planning. On 7/15/25, at 2:28 p.m., registered nurse (RN)-B stated the facility obtained R1's correct colostomy supplies after he went to the hospital on 6/25/25. RN-B stated the colostomy supplies were in the residents' rooms. She stated, "There is not anything in the care plan for the step-by-step process or the specific products required." RN-B stated she had changed R1's colostomy on one occasion. She stated she could not confirm if the physician order was followed at that time. She stated she had not seen the order. She stated his appointment with the ostomy clinic had not been arranged due to transportation issues with family. On 7/15/25, at 3:01 p.m., the director of nursing (DON) stated the HUC enters the physician orders. She stated physician orders were to be entered in the system exactly as they were written. The DON stated the facility had attempted to use their formulary colostomy supplies. The DON stated, "the order is part of the care plan." The DON also stated, "the order feeds the MAR." The DON stated the facility did not have an ostomy nurse on staff. She stated R1 was in the process of discharging. The DON stated the facility did not have a policy for ostomy care. A facility document, Ostomy Care Orientation Checklist, undated, directed to check the client care plan as the first step in the process. A facility document, Skill Competency Medication and Treatment, undated, Ostomy Care directed to check the client care plan as the first step. A facility document, Physician Services, dated 2022, directed all physician orders will be followed as prescribed and if not followed, the reason shall be recorded in the resident's medical record during that	F0691		

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F0691 SS = D	Continued from page 16 shift. A facility document, Comprehensive Assessments and Care Planning, dated 2017, the purpose of the policy was to provide a comprehensive person-centered interdisciplinary care assessment of the resident's condition, in order to develop consistent quality care that will attain or maintain the highest practicable physical, mental and psychological functioning possible, a facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. 2)The assessment process begins with the development of the baseline care plan within the first 48 hours of admission. The baseline care plant includes the minimum healthcare information necessary to care for each resident immediately upon their admission, which would address resident-specific health and safety concerns to prevent decline or injury. Baseline care plans address, at a minimum, the following: physician orders. 6) The assessment must include at least the following: j) special treatment and procedures. 11) All person-centered care plan interventions will be implemented by qualified personnel. Interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication.	F0691		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 11, 2025

Administrator
REGINA SENIOR LIVING
1175 NININGER ROAD
HASTINGS, MN 55033

Re: State Nursing Home Licensing Orders
Event ID: OM3I11

Dear Administrator:

The above facility was surveyed on July 15, 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:

Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGINA SENIOR LIVING	**1175 NININGER ROAD , HASTINGS, Minnesota, 55033**

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/15/25, 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		08/20/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2025

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20000	Continued from page 1 The following complaints were reviewed. H52548171C (MN00114200) with licensing orders issued at 4658.0405, Subpart 1 and Subpart 3. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for	20555	· Care Conference for R1 held with full interdisciplinary team to review care plan and treatment goals on 07/16/2025. · All facility residents were reviewed to ensure Care Conferences were up to date and/or scheduled . · Social Work Designee received education regarding coordinating and scheduling care conferences in a	08/20/2025

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20555	Continued from page 2 the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to develop and implement a comprehensive, individualized care plan for 1 of 3 residents (R1) reviewed for ostomy care. The facility failed to have a process in place to instruct staff on physician ordered ostomy care. This resulted in R1's colostomy bag leaking on multiple occasions and emotional distress for R1. Findings include: R1's care plan, dated 6/6/25, indicated he required assist of one staff for personal cares. The care plan lacked individualized care for R1's colostomy, as it did not specify the supplies requires or the process to complete the colostomy care. R1's medication administration record (MAR), dated June and July 2025, directed to change ostomy bag two times weekly and as needed for leakage, on Monday and Wednesday evenings. R1's bowel assessment, dated 6/8/25, failed to appropriately assess his ostomy site with measurements and description. R1's admission Minimum Data Set, dated 6/11/25, indicated R1 had diagnoses of Crohn's disease (chronic inflammatory bowel disease) and had a colostomy (a surgical procedure that creates an opening in the abdominal wall, bringing a portion of the large intestine to the surface). R1's MDS indicated he was cognitively intact. A progress note, on 6/11/25, indicated colostomy bag was changed. Hollister brand used and cut to measure to size of stoma. Skin surrounding stoma is clean, intact and free of breakdown/maceration. No redness, foul odor or signs/symptoms of infection. A progress note, on 6/25/25, indicated colostomy bag and appliance changed. Area is red and macerated around appliance. Skin barrier applied. Patient denies pain but voices that this is not typical appliance he uses at home. Facility will order device familiar to	20555	Continued from page 2 timely manner; while meeting requirements of resident participation in care planning. · Social Work Designee will audit care conferences weekly for completion of those that are required based off the quarterly schedule; for 6 weeks. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2025
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20555	Continued from page 3	20555		

patient.

A progress note, on 6/25/25, indicated R1 was up the majority of the night dealing with his colostomy bag. R1 was in clear emotional distress. He reported to writer that he is "traumatized and devastated" and began to become tearful stating he got no sleep. The progress note indicated he was very upset and stated, “I should just put a shotgun to my head” and making comments he did not want to be alive anymore.

On 7/15/25, at 10:21 a.m., R1 stated he had several episodes of his colostomy leaking in the first 20 days at the facility. R1 stated he repeatedly asked the facility to use the products he was familiar with, including rings (intended to create a secure and comfortable seal between an ostomy pouch and the skin around the stoma, to prevent leakage) and wings (small flexible pieces of hydrocolloid adhesive that attach to the edges of an ostomy skin barrier to provide extra security and prevent leaks). R1 stated the facility started providing the requested supplies, after he became suicidal due to lack of sleep, from the colostomy leaking four times on 6/25/25. R1 stated his colostomy has had fewer incidents of leaking since the facility has provided the supplies he needed.

On 7/15/25, at 1:14 p.m., licensed practical nurse (LPN)-B stated R1’s colostomy bag changes required the use of skin prep (creates a protective barrier) and the supplies located in his room. She stated the orders in his chart indicated frequency of scheduled colostomy changes.

On 7/15/25, at 1:32 p.m., LPN-A stated the facility did not have the exact supplies R1 wanted for his colostomy, as the facility had formulary colostomy supplies. She stated he was experiencing more incidents of leaking during his first few weeks at the facility. She stated she obtained the required products after he was sent to the hospital on 6/25/25. She stated R1 taught the staff how to perform the colostomy bag changes. She stated two other products were tried for him prior to using the supplies he was prescribed. She stated the supplies for each resident were placed in their rooms. She stated the care plan did not list the process or specific supplies required. She stated she expected the nurses would know how to change the colostomy bags. LPN-A stated the HUC should have listed all the steps ordered by the physician for the colostomy care in the orders for R1.

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20555	Continued from page 4 On 7/15/25, at 2:28 p.m., registered nurse (RN)-B stated the facility obtained R1's correct colostomy supplies after he went to the hospital on 6/25/25. RN-B stated the colostomy supplies were located in the residents' rooms. She stated, "There is not anything in the care plan for the step-by-step process or the specific products required." RN-B stated she had changed R1's colostomy on one occasion. She stated she could not confirm if the physician order was followed at that time. She stated she had not seen the order. On 7/15/25, at 3:01 p.m., the director of nursing (DON) stated, "the order is part of the care plan." The DON also stated, "the order feeds the MAR." She stated the facility was using formulary colostomy supplies. She stated there was not an order from the physician to use the facility's formulary colostomy supplies or change the physician ordered process. A facility document, Comprehensive Assessments and Care Planning, dated 2017, directed the facility must make a comprehensive assessment of the resident's needs. Baseline care plans address at a minimum, the following: physician orders. The assessment must include at least the following: Continence and Special treatment and procedures. A facility should use the results of the assessment to develop, review and revise the resident's person-centered comprehensive care plan. All person-centered care plan interventions will be implemented by qualified personnel. Interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could provide education to the leadership team regarding the importance of including residents in the development of their individualized plan of care. The DON or designee could perform an audit to assess compliance with including residents in the care planning process and report findings to the Quality Assessment and Performance Improvement (QAPI) committee. The QAPI committee could monitor compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20555		
20565	Comprehensive Plan of Care; Use	20565	· Physician orders for colostomy cares clarified for R1. Care plan for R1 was updated to include	08/20/2025

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20565	Continued from page 5 CFR(s): MN Rule 4658.0405 Subp. 3 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to develop and implement a comprehensive, individualized care plan for 1 of 3 residents (R1) reviewed for ostomy care. The facility failed to have a process in place to instruct staff on physician ordered ostomy care. This resulted in R1's colostomy bag leaking on multiple occasions and emotional distress for R1. Findings include: R1's care plan, dated 6/6/25, indicated he required assist of one staff for personal cares. The care plan lacked individualized care for R1's colostomy, as it did not specify the supplies requires or the process to complete the colostomy care. R1's medication administration record (MAR), dated June and July 2025, directed to change ostomy bag two times weekly and as needed for leakage, on Monday and Wednesday evenings. R1's bowel assessment, dated 6/8/25, failed to appropriately assess his ostomy site with measurements and description. R1's admission Minimum Data Set, dated 6/11/25, indicated R1 had diagnoses of Crohn's disease (chronic inflammatory bowel disease) and had a colostomy (a surgical procedure that creates an opening in the abdominal wall, bringing a portion of the large intestine to the surface). R1's MDS indicated he was cognitively intact. A progress note, on 6/11/25, indicated colostomy bag was changed. Hollister brand used and cut to measure to size of stoma. Skin surrounding stoma is clean, intact and free of breakdown/maceration. No redness, foul odor or signs/symptoms of infection. A progress note, on 6/25/25, indicated colostomy bag and appliance changed. Area is red and macerated around appliance. Skin barrier applied. Patient denies pain but voices that this is not typical appliance he uses at home. Facility will order device familiar to patient.	20565	Continued from page 5 individualized approaches for colostomy cares. · All facility residents with colostomy orders reviewed and care plans updated accordingly to include individualized approaches . · Nursing staff received education regarding colostomy cares, initiating and adjusting resident care plans, and colostomy order entry. · Colostomy cares will be audited weekly for 6 weeks to ensure proper order entry and care delivered. Results of audits shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results if substantial compliance is not met.	

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20565	Continued from page 6 A progress note, on 6/25/25, indicated R1 was up the majority of the night dealing with his colostomy bag. R1 was in clear emotional distress. He reported to writer that he is "traumatized and devastated" and began to become tearful stating he got no sleep. The progress note indicated he was very upset and stated, “I should just put a shotgun to my head” and making comments he did not want to be alive anymore. On 7/15/25, at 10:21 a.m., R1 stated he had several episodes of his colostomy leaking in the first 20 days at the facility. R1 stated he repeatedly asked the facility to use the products he was familiar with, including rings (intended to create a secure and comfortable seal between an ostomy pouch and the skin around the stoma, to prevent leakage) and wings (small flexible pieces of hydrocolloid adhesive that attach to the edges of an ostomy skin barrier to provide extra security and prevent leaks). R1 stated the facility started providing the requested supplies, after he became suicidal due to lack of sleep, from the colostomy leaking four times on 6/25/25. R1 stated his colostomy has had fewer incidents of leaking since the facility has provided the supplies he needed. On 7/15/25, at 1:14 p.m., licensed practical nurse (LPN)-B stated R1’s colostomy bag changes required the use of skin prep (creates a protective barrier) and the supplies located in his room. She stated the orders in his chart indicated frequency of scheduled colostomy changes. On 7/15/25, at 1:32 p.m., LPN-A stated the facility did not have the exact supplies R1 wanted for his colostomy, as the facility had formulary colostomy supplies. She stated he was experiencing more incidents of leaking during his first few weeks at the facility. She stated she obtained the required products after he was sent to the hospital on 6/25/25. She stated R1 taught the staff how to perform the colostomy bag changes. She stated two other products were tried for him prior to using the supplies he was prescribed. She stated the supplies for each resident were placed in their rooms. She stated the care plan did not list the process or specific supplies required. She stated she expected the nurses would know how to change the colostomy bags. LPN-A stated the HUC should have listed all the steps ordered by the physician for the colostomy care in the orders for R1.	20565		

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20565	Continued from page 7 On 7/15/25, at 2:28 p.m., registered nurse (RN)-B stated the facility obtained R1's correct colostomy supplies after he went to the hospital on 6/25/25. RN-B stated the colostomy supplies were located in the residents' rooms. She stated, "There is not anything in the care plan for the step-by-step process or the specific products required." RN-B stated she had changed R1's colostomy on one occasion. She stated she could not confirm if the physician order was followed at that time. She stated she had not seen the order. On 7/15/25, at 3:01 p.m., the director of nursing (DON) stated, "the order is part of the care plan." The DON also stated, "the order feeds the MAR." She stated the facility was using formulary colostomy supplies. She stated there was not an order from the physician to use the facility's formulary colostomy supplies or change the physician ordered process. A facility document, Comprehensive Assessments and Care Planning, dated 2017, directed the facility must make a comprehensive assessment of the resident's needs. Baseline care plans address at a minimum, the following: physician orders. The assessment must include at least the following: Continence and Special treatment and procedures. A facility should use the results of the assessment to develop, review and revise the resident's person-centered comprehensive care plan. All person-centered care plan interventions will be implemented by qualified personnel. Interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could provide education to the leadership team regarding the importance of implementing individualized care plans for residents, for their specific treatments. The DON or designee could perform an audit to assess compliance and report findings to the Quality Assessment and Performance Improvement (QAPI) committee. The QAPI committee could monitor compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20565		