



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 17, 2026

Administrator
BENEDICTINE HEALTH CENTER OF MINNEAPOLIS
618 EAST 17TH STREET
MINNEAPOLIS, MN 55404

RE: CCN: 245266

Cycle Start Date: July 6, 2026

Dear Administrator:

On August 11, 2026, 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.

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

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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August 17, 2026

Administrator
BENEDICTINE HEALTH CENTER OF MINNEAPOLIS
618 EAST 17TH STREET
MINNEAPOLIS, MN 55404

Re: Reinspection Results
Event ID: 25C55E-H2

Dear Administrator:

On August 11, 2026 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 6, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
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Protecting, Maintaining and Improving the Health of All Minnesotans

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July 22, 2026

Administrator
BENEDICTINE HEALTH CENTER OF MINNEAPOLIS
618 EAST 17TH STREET
MINNEAPOLIS, MN 55404

RE: CCN:245266
Cycle Start Date: July 6, 2026

Dear Administrator:

On July 6, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by October 6, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 6, 2027 (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
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July 22, 2026

Administrator

BENEDICTINE HEALTH CENTER OF MINNEAPOLIS

618 EAST 17TH STREET

MINNEAPOLIS, MN 55404

Re: State Nursing Home Licensing Orders

Event ID: 25C55E-H1

Dear Administrator:

The above facility survey was completed on July 6, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/06/2026	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER OF MINNEAPOLIS				STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET , MINNEAPOLIS, Minnesota, 55404			
(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 7/1/26 through 7/2/26 and 7/6/26, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52663133C (3064047) and H52663013C (3051345) with citations issued at F686, F880 and F580. 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.			F0000			07/27/2026
F0580 SS = D	Notify of Changes (Injury/Delirium/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or			F0580	"This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements." R1's physician was notified of her Left ankle pressure injury noted on 07/01/2026 while in facility same day. All resident with pressure injuries were reviewed for change in conditions and providers notified of any identified changes. Change in Condition Resident Examination and Assessment Policy was reviewed and remains current. Education was completed with all Nurses on provider notification with change in condition		08/05/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/06/2026	
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F0580 SS = D	Continued from page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide timely notification for change in condition to the physician for 1 of 3 residents (R1) reviewed for pressure ulcers. R1's hospital discharge summary note dated 6/11/26 identified R1's diagnoses included respiratory failure with hypoxia, anoxic brain damage and encephalopathy, very fragile with many skin tears/wounds to all extremities, a deep tissue pressure injury (DTPI) recurrent fevers/sepsis workup. R1's hospital wound care instructions dated 6/11/26 included:			F0580	Continued from page 1 including any newly identified, deteriorating or stalled wounds. DON or designee will audit all wounds for 6 weeks to determine if there were any newly identified, deteriorating or stalled wounds and verify provider notification for change in condition. All Audits will be reported to the facility QAPI committee to determine the need/frequency for further auditing.		08/05/2026

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F0580 SS = D	Continued from page 2 -Coccyx -zinc barrier two times a day (BID) and as needed (PRN) soiling. -Left lateral ankle – cleanse with normal saline (NS). Apply medical grade honey gel. Cover with mepilex dressing. Change Monday, Wednesday, Friday (MWF) and PRN soiling. R1's admission Minimum Data Set (MDS) dated 6/30/25 indicated R1 is at risk of developing pressure ulcers (PU). The MDS also indicated R1 required extensive total assistance with activities of daily living (ADL). R1's care plan dated 6/30/26, indicated R1 had severe cognition impairment and was at risk for skin breakdown related to pressure due to incontinence, inactivity, immobility, and problem with friction and shearing with staff interventions to inspect skin with care, to evaluate and notify the provider and the family immediately of any new area of skin breakdown. R1's wound report document dated 7/01/26 at 12:57 p.m. R1 had 1.5 cm x 1 cm unspecified ulcer at left ankle. Facility wound summary report dated 7/1/26 provided to the nurse practitioner did not identify R1's left ankle pressure ulcer. During an observation on 7/6/26 at 10:30 a.m., the director of nursing (DON) identified R1 had 1.5 cm x 1 cm PU on the left ankle with scant serosanguinous drainage, no odor noted. On 7/6/26 at 4:59 p.m., director of nursing (DON) stated she expected nursing staff to follow the facility's wound care policy. The DON stated when new or existing skin impairment was identified, nursing staff were required to notify the wound care team, document the measurements and the description. The DON stated she was unable to find an updated care plan related to R1's left ankle PU identified on 7/1/26. The DON confirmed nursing staff did not notify the provider regarding the finding. On 7/6/26 at 12:40 p.m., a nurse practitioner (NP)-A stated she expected nursing staff to follow the facility's change in condition and wound care policies. NP-A stated nursing staff were required to notify the provider of a new or an existing skin impairment status, depending on the resident			F0580			08/05/2026

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F0580 SS = D	Continued from page 3 diagnosis and condition. NP-A confirmed she was not notified regarding R1's left ankle PU. Notification of Changes Policy dated 11/10/2025 directed the facility staff to make appropriate and timely notification to the physician and delegated non-physician practitioner and notification to the resident representative when there is a change in the resident's condition that may require physician intervention. Notify the provider of any abnormalities such as, but not limited to, wounds or rashes on the resident's skin. Document symptom(s), assessment, observations, resident representative and medical provider notification. Monitor and provide treatment as ordered by the attending provider.			F0580			08/05/2026
F0686 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 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 identify, monitor, and provide care consistent with professional standard of practice to an existing pressure injury for 1 of 3 residents (R1) reviewed for pressure sores. R1's hospital discharge summary note dated 6/11/26 identified R1's diagnoses included respiratory failure with hypoxia, anoxic brain damage and encephalopathy, very fragile with many skin tears/wounds to all extremities, a deep tissue pressure injury (DTPI) recurrent fevers/sepsis workup. R1's hospital wound care instructions dated 6/11/26			F0686	"This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements." R1's Pressure injury to the Left ankle was documented and measured on 7/1/26. R1's care plan was updated to reflect all current wounds. All residents with pressure injuries were reviewed and have current measurements, treatments and care plans in place. Prevention and Treatment of Skin Breakdown (Pressure) Policy was reviewed and remains current. All nursing staff were educated on identifying wounds including measurements, orders, provider and responsible party notification and documentation. Nurses were also educated on the expectation of assessing wounds on admission and every 7days with provider notification on newly identified, deteriorating or stalled wounds and must be care planned. DON or designee will audit all wounds for 6 weeks to verify that measurements are completed every 7 days with updated care plans and documentation.		08/05/2026

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F0686 SS = D	Continued from page 4 included the following: Left lateral ankle: Cleanse with normal saline (NS). Apply medical grade honey gel. Cover with mepilex dressing. Change Monday, Wednesday, Friday (MWF) and PRN (as needed) soiling. R1's admission Minimum Data Set (MDS) dated 6/30/25 indicated R1 is at risk of developing pressure ulcers. The MDS also indicated R1 required extensive total assistance with activities of daily living (ADL). R1's care plan dated 6/30/26, indicated R1 had severe cognition impairment and was at risk for skin breakdown related to pressure due to incontinence, inactivity, immobility, and problem with friction and shearing with staff interventions to inspect skin with care, to evaluate and notify the provider and the family immediately of any new area of skin breakdown. R1's skin evaluation document, dated 6/11/25 at 7:08 p.m. indicated R1 had unhealed pressure injuries in the sacral area. The evaluation did not address R1's left ankle. R1's wound report identified a mid-thoracic back pressure ulcer and a right lower back pressure ulcer, however, did not address R1's left ankle. Review of R1's medical record including skin assessments and progress notes lacked documentation of PU assessment for the left ankle, including measurements, or wound description from 6/11/25 through 6/21/25. During this time period, facility nursing staff were responsible for monitoring and maintaining R1's skin integrity. On 6/21/26 at 11:53 a.m., a progress note indicated R1 had increased heart rate and elevated temperature. Nursing staff sent R1 to the hospital for further evaluation per the provider's order. R1's hospital discharge summary note dated 7/1/26, identified R1 had a history of anoxic injury status post ventricular fibrillation (V-fib) arrest, was dependent on chronic ventilator, and had Percutaneous Endoscopic Gastrostomy (PEG) tube (flexible feeding tube placed directly into the stomach) and indwelling catheter. R1 was admitted to the hospital from the facility on 6/21/26 with severe sepsis and a fever of 103.5 Fahrenheit (F). On 7/1/26 at 3:24 p.m., a progress note indicated R1 returned from the hospital at approximately 11:30			F0686	Continued from page 4 All Audits will be reported to the facility QAPI committee to determine the need/frequency for further auditing.		08/05/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/06/2026	
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F0686 SS = D	Continued from page 5 a.m., nursing staff completed skin assessments and performed wound dressing changes. R1's wound report document dated 7/01/26 at 12:57 p.m. identified R1 had 1.5 cm x 1 cm unspecified ulcer at left ankle. During an observation on 7/6/26 at 10:30 a.m., the director of nursing (DON) identified R1 had 1.5 cm x 1 cm PU on the left ankle with scant serosanguinous drainage, no odor noted. During an observation on 7/6/26 at 10:58 a.m., a registered nurse (RN)-A stated R1 had a stage 4 PU on the coccyx area, an excoriation surrounding the wound, and 30% slough present in the wound bed. During continuous observation, R1' s coccyx wound bed was noted to be in contact with the draw sheet. During an interview on 7/1/26 at 12:32 p.m., a registered nurse (RN)-A stated nursing staff had a form to document the skin assessments for the new admissions, including wound measurement and/or descriptions. RN-A explained during a weekly skin assessment, nursing staff were expected to assess existing wounds, compare findings, and document the wounds' progress. RN-A stated any new skin impairment identified should be communicated to the nurse manager and the provider for further instructions. RN-A further stated staff were required to follow the facility infection protocol during wound care. During an interview on 7/1/26 at 2:44 p.m., RN-B stated she assisted the nurse manager, RN-C, with R1's readmission skin assessment. RN-B stated R1 had been hospitalized for six days due to sepsis and had recently returned to the facility. RN-B explained R1 had fragile skin, skin tears on upper and lower extremities, and a PU at the coccyx. RN-B confirmed RN-C was responsible for documenting the status, measurements, and/ or descriptions of the wounds. RN-B stated she was unaware of R1's PU located on the left ankle. During an interview on 7/2/26 at 4:26 p.m., RN-C stated when a new skin impairment was identified, nursing staff were expected to complete an assessment, provide description, and measurements, document the finding in the progress note, notified the nurse manager and the provider, initiate treatment according to the provider's orders, and inform the family. RN-C stated nursing staff did not document any measurement or description about R1's PU at the left ankle from 6/11/26 through 6/21/26. RN-C stated nurses were required to			F0686			08/05/2026

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F0686 SS = D	Continued from page 6 document the size, characteristics, status of existing or reopened skin impairments, and initiated risk management interventions. During an interview on 7/6/26 at 4:59 p.m., the DON stated she expected nursing staff to follow the facility's wound care policy. The DON stated when new skin impairment was identified, nursing staff were required to notify the wound care team, document the measurements and the description. The DON was unable to find an updated care plan related to R1's left ankle PU identified on 7/1/26. The DON confirmed nursing staff did not notify the provider regarding the finding. During an interview on 7/6/26 at 12:40 p.m., a nurse practitioner (NP)-A stated she expected nursing staff to follow the facility's change in condition and wound care policies. NP-A stated nursing staff were required to notify the provider of a new skin impairment, depending on the resident diagnosis and condition. NP-A confirmed she was not notified regarding R1's left ankle PU. The facility Wound Care policy dated 9/1/2018 indicated if a resident is admitted with impaired skin integrity or a new pressure injury or lower extremity wound develops nursing staff implements the following item: Documentation of the skin impairment is completed in the medical record. Staging of Pressure Injury is completed as necessary by trained licensed associates. Standing orders/protocol for skin wound are initiated. Notify attending provider and resident representative. Attending provider determines wound type and may provide additional orders. Notify Supervisor/designee. Evaluate current pressure reduction interventions and revise resident centered care plan. When pressure injury is present, the dressing and/or wound is monitored, as appropriate. Weekly the licensed nurse will stage, measure, and examine the wound bed and the surrounding skin. If wound bed has deteriorated; notify provider.			F0686			08/05/2026

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F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must			F0880	"This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements." R2 and R3 have Enhanced Barrier Precaution signage posted appropriately at their door and care plans are up to date with EBP. Mechanical lift was disinfected on 7/2/2026. All residents who require EBP have been reviewed and have appropriate signage and updated care plans. All shared equipment was disinfected on 7/2/2026. Enhanced Barrier Precaution and Resident Care Equipment Policies were reviewed and remain current. NA-A, NA-B, RN-A, RN-E received corrective action on following Enhanced Barrier Precautions appropriately. Education was provided to all staff on Enhanced Barrier Precautions and where to find information on which residents are on EBP. Nursing staff were given a post test knowledge check to verify understanding of the expectations. Education was provided to nursing staff on disinfecting shared equipment between residents. DON or designee will conduct 3 random audits per floor per week for 6 weeks to verify correct usage of PPE with EBP and proper shared equipment disinfection. All Audits will be reported to the facility QAPI committee to determine the need/frequency for further auditing.		08/05/2026

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F0880 SS = D	Continued from page 8 prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: The facility failed to ensure transmission-based precautions were followed for 2 of 4 (R2 and R3) residents observed for proper infection control practices. Findings include: R2 R2's Admission Record dated 7/12/2024, indicated R2's diagnoses included anoxic brain damage, tracheostomy (a surgically created opening in the front of the neck and directly into the windpipe), unspecified protein-calorie malnutrition, systemic inflammatory response syndrome (SIRS) and tube-feeding. R2's quarterly Minimum Data Set (MDS) dated 6/16/26, indicated R2 had severe cognitive impairment and required total extensive assistance of two persons with mechanical lift for transfers. R2's care plan dated 4/23/26, indicated R2 required Enhanced Barrier Precautions (EBP) related to aspiration pneumonia, chronic respiratory failure, and the presence of tracheostomy and gastrostomy tube. The care plan also indicated R2 was dependent			F0880			08/05/2026

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F0880 SS = D	Continued from page 9 on staff for toilet hygiene and transfers with staff interventions included posting clear signage on the door indicating the type of precautions and following EBP direction while providing high contact care activities. During an observation on 7/2/26 at 11:05 a.m., a nursing assistant (NA)-B and RN-A were observed transferring R2 whose room had EBP signage posted on the door. Neither NA-B nor RN-A donned a gown before providing care. NA-B removed the soiled bedding and made the bed without wearing a gown. After the transfer, NA-B picked up the soiled linen from the floor of the resident's room. RN-A parked the mechanical lift in the hallway after use without cleaning or disinfecting the equipment. During an interview on 7/2/26 at 10:23 a.m. NA-B stated a gown, and gloves were expected to be worn during transfers for residents on EBP. NA-B confirmed he should have worn a gown and gloves while providing high contact care activity to R2. During an interview on 7/2/26 at 11:53 a.m., RN-A stated staff usually donned a gown during high-contact activities with R2. RN-A stated EBP signage directed staff on the appropriate PPE (Personal Protective Equipment) to wear based on the care being provided; however, he was unsure whether R2 was on EBP. RN-A confirmed he did not wear a gown while transferring R2 with the mechanical lift and forgot to disinfect the lift after use. RN-A stated the lift should be cleaned after each use to prevent cross-contamination. R3 R3's Admission Record dated 8/12/2020, indicated R3's diagnoses included traumatic subdural hemorrhage, chronic respiratory failure with hypoxia , tracheostomy, gastrostomy, osteomyelitis, and disruption of wound. R3's quarterly Minimum Data Set (MDS) dated 16/26/26, indicated R1 had severe cognitive impairment and required total extensive assistance of two persons with mechanical lift for transfers. R3's care plan dated 6/22/26 indicated R3 had gastrostomy-tube site and an open area on the abdomen , as well as tracheostomy. The care plan also indicated R3 was dependent on staff for toilet hygiene and transfers with staff interventions included monitor tube site for sign/symptoms of			F0880			08/05/2026

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F0880 SS = D	Continued from page 10 infection and reporting any concerns to the provider, as well as following EBP during high-contact care activities. During an observation on 7/1/26 at 12:01 p.m., NA-A exited R4's room which had EBP signage posted on the door, while still wearing a gown and gloves. Without removing the gown and gloves, NA-A entered R3's room to get a large brief and then returned to R4's room to continue providing care. During an interview on 7/1/26 at 12:27 p.m., NA-A stated she had received training regarding the facility's infection control protocols. NA-A stated she was providing bed toileting to R4 whose room had EBP signage posted on the door and needed a clean brief. NA-A stated she obtained the brief from R3's room while still wearing a gown and gloves. NA-A stated she should have removed her gown and gloves before leaving R4's room to obtain supplies in order to prevent cross contamination. During an observation on 7/6/26 at 8:47 a.m., RN-E provided trach care and tube-feeding to R3 without wearing a gown. R3's room had EBP signage posted on the door directed staff to wear appropriate PPE. During an interview on 7/6/26 at 9:00 a.m., RN-E stated when a resident had tracheostomy and gastrostomy tube, staff should post EBP signage on the resident's door and follow the facility's infection protocols. RN-E confirmed she did not wear a gown while providing tracheostomy care and administering tube-feeding to R3. RN-E stated she knew the appropriate procedure and should have worn the required PPE to help prevent the transmission of infection. During an interview on 7/6/26 at 4:58 a.m., the director of nursing (DON) stated she expected all staff to be knowledgeable about EBP and to wear appropriate PPE when providing high-contact care to residents on EBP. The facility Enhanced Barrier Precaution policy dated 4/1/2024 indicated enhanced barrier precautions should be followed outside the resident's room when performing transfers and assisting during a high contact activity such as bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility, or any high-contact activities included dressing, transferring, changing			F0880			08/05/2026

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F0880 SS = D	Continued from page 11 linens, and device care or use such urinary catheters, feeding tubes, and tracheostomy.			F0880			08/05/2026

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/1/26 through 7/2/26 and 7/6/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following complaints were reviewed: H52663133C (3064047) and H52663013C (3051345) with licensing orders issued at 20265, 20900 and 21385. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal			20000			07/27/2026

Office of Primary Care and Health Systems Management

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

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20000	Continued from page 1 software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		20000			07/27/2026	
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide timely notification for change in condition to the physician for 1 of 3 residents (R1) reviewed for pressure ulcers.		20265	Corrected		08/05/2026	

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20265	Continued from page 2 Findings include: R1's hospital discharge summary note dated 6/11/26 identified R1's diagnoses included respiratory failure with hypoxia, anoxic brain damage and encephalopathy, very fragile with many skin tears/wounds to all extremities, a deep tissue pressure injury (DTPI) recurrent fevers/sepsis workup. R1's hospital wound care instructions dated 6/11/26 included: -Coccyx -zinc barrier two times a day (BID) and as needed (PRN) soiling. -Left lateral ankle – cleanse with normal saline (NS). Apply medical grade honey gel. Cover with mepilex dressing. Change Monday, Wednesday, Friday (MWF) and PRN soiling. R1's admission Minimum Data Set (MDS) dated 6/30/25 indicated R1 is at risk of developing pressure ulcers (PU). The MDS also indicated R1 required extensive total assistance with activities of daily living (ADL). R1's care plan dated 6/30/26, indicated R1 had severe cognition impairment and was at risk for skin breakdown related to pressure due to incontinence, inactivity, immobility, and problem with friction and shearing with staff interventions to inspect skin with care, to evaluate and notify the provider and the family immediately of any new area of skin breakdown. R1's wound report document dated 7/01/26 at 12:57 p.m. R1 had 1.5 cm x 1 cm unspecified ulcer at left ankle. Facility wound summary report dated 7/1/26 provided to the nurse practitioner did not identify R1's left ankle pressure ulcer. During an observation on 7/6/26 at 10:30 a.m., the director of nursing (DON) identified R1 had 1.5 cm x 1 cm PU on the left ankle with scant serosanguinous drainage, no odor noted. On 7/6/26 at 4:59 p.m., director of nursing (DON) stated she expected nursing staff to follow the facility's wound care policy. The DON stated when new or existing skin impairment was identified, nursing staff were required to notify the wound care			20265			08/05/2026

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20265	Continued from page 3 team, document the measurements and the description. The DON stated she was unable to find an updated care plan related to R1's left ankle PU identified on 7/1/26. The DON confirmed nursing staff did not notify the provider regarding the finding. On 7/6/26 at 12:40 p.m., a nurse practitioner (NP)-A stated she expected nursing staff to follow the facility's change in condition and wound care policies. NP-A stated nursing staff were required to notify the provider of a new or an existing skin impairment status, depending on the resident diagnosis and condition. NP-A confirmed she was not notified regarding R1's left ankle PU. Notification of Changes Policy dated 11/10/2025 directed the facility staff to make appropriate and timely notification to the physician and delegated non-physician practitioner and notification to the resident representative when there is a change in the resident's condition that may require physician intervention. Notify the provider of any abnormalities such as, but not limited to, wounds or rashes on the resident's skin. Document symptom(s), assessment, observations, resident representative and medical provider notification. Monitor and provide treatment as ordered by the attending provider. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review notification of changes policies and procedures to make appropriate and timely notification to the physician and resident's representative. Staff could be educated on the need to make appropriate and timely notification to the physician and resident's representative with supporting assessments. The DON or designee could review all current resident orders to ensure timely notification to the physician/resident's representative of any changes in condition and audit periodically per recommendation from the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time. Those results could be taken back to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20265			08/05/2026	
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3		20900	Corrected		08/05/2026	

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20900	Continued from page 4 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and monitor a pressure ulcer to prevent or reduce the risk of deterioration for 1 of 3 residents (R1) reviewed for pressure sores. Findings include: R1's hospital discharge summary note dated 6/11/26 identified R1's diagnoses included respiratory failure with hypoxia, anoxic brain damage and encephalopathy, very fragile with many skin tears/wounds to all extremities, a deep tissue pressure injury (DTPI) recurrent fevers/sepsis workup. R1's hospital wound care instructions dated 6/11/26 included the following: Left lateral ankle: Cleanse with normal saline (NS). Apply medical grade honey gel. Cover with mepilex dressing. Change Monday, Wednesday, Friday (MWF) and PRN (as needed) soiling. R1's admission Minimum Data Set (MDS) dated 6/30/25 indicated R1 is at risk of developing pressure ulcers. The MDS also indicated R1 required extensive total assistance with activities of daily living (ADL). R1's care plan dated 6/30/26, indicated R1 had severe cognition impairment and was at risk for skin breakdown related to pressure due to incontinence, inactivity, immobility, and problem with friction and shearing with staff interventions to inspect skin with			20900			08/05/2026

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20900	Continued from page 5 care, to evaluate and notify the provider and the family immediately of any new area of skin breakdown. R1's skin evaluation document, dated 6/11/25 at 7:08 p.m. indicated R1 had unhealed pressure injuries in the sacral area. The evaluation did not address R1's left ankle. R1's wound report identified a mid-thoracic back pressure ulcer and a right lower back pressure ulcer, however, did not address R1's left ankle. Review of R1's medical record including skin assessments and progress notes lacked documentation of PU assessment for the left ankle, including measurements, or wound description from 6/11/25 through 6/21/25. During this time period, facility nursing staff were responsible for monitoring and maintaining R1's skin integrity. On 6/21/26 at 11:53 a.m., a progress note indicated R1 had increased heart rate and elevated temperature. Nursing staff sent R1 to the hospital for further evaluation per the provider's order. R1's hospital discharge summary note dated 7/1/26, identified R1 had a history of anoxic injury status post ventricular fibrillation (V-fib) arrest, was dependent on chronic ventilator, and had Percutaneous Endoscopic Gastrostomy (PEG) tube (flexible feeding tube placed directly into the stomach) and indwelling catheter. R1 was admitted to the hospital from the facility on 6/21/26 with severe sepsis and a fever of 103.5 Fahrenheit (F). On 7/1/26 at 3:24 p.m., a progress note indicated R1 returned from the hospital at approximately 11:30 a.m., nursing staff completed skin assessments and performed wound dressing changes. R1's wound report document dated 7/01/26 at 12:57 p.m. identified R1 had 1.5 cm x 1 cm unspecified ulcer at left ankle. During an observation on 7/6/26 at 10:30 a.m., the director of nursing (DON) identified R1 had 1.5 cm x 1 cm PU on the left ankle with scant serosanguinous drainage, no odor noted. During an observation on 7/6/26 at 10:58 a.m., a registered nurse (RN)-A stated R1 had a stage 4 PU on the coccyx area, an excoriation surrounding the wound, and 30% slough present in the wound bed. During continuous observation, R1' s coccyx wound bed was noted to be in contact with the draw sheet.			20900			08/05/2026

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20900	Continued from page 6 During an interview on 7/1/26 at 12:32 p.m., a registered nurse (RN)-A stated nursing staff had a form to document the skin assessments for the new admissions, including wound measurement and/or descriptions. RN-A explained during a weekly skin assessment, nursing staff were expected to assess existing wounds, compare findings, and document the wounds' progress. RN-A stated any new skin impairment identified should be communicated to the nurse manager and the provider for further instructions. RN-A further stated staff were required to follow the facility infection protocol during wound care. During an interview on 7/1/26 at 2:44 p.m., RN-B stated she assisted the nurse manager, RN-C, with R1's readmission skin assessment. RN-B stated R1 had been hospitalized for six days due to sepsis and had recently returned to the facility. RN-B explained R1 had fragile skin, skin tears on upper and lower extremities, and a PU at the coccyx. RN-B confirmed RN-C was responsible for documenting the status, measurements, and/ or descriptions of the wounds. RN-B stated she was unaware of R1's PU located on the left ankle. During an interview on 7/2/26 at 4:26 p.m., RN-C stated when a new skin impairment was identified, nursing staff were expected to complete an assessment, provide description, and measurements, document the finding in the progress note, notified the nurse manager and the provider, initiate treatment according to the provider's orders, and inform the family. RN-C stated nursing staff did not document any measurement or description about R1's PU at the left ankle from 6/11/26 through 6/21/26. RN-C stated nurses were required to document the size, characteristics, status of existing or reopened skin impairments, and initiated risk management interventions. During an interview on 7/6/26 at 4:59 p.m., the DON stated she expected nursing staff to follow the facility's wound care policy. The DON stated when new skin impairment was identified, nursing staff were required to notify the wound care team, document the measurements and the description. The DON was unable to find an updated care plan related to R1's left ankle PU identified on 7/1/26. The DON confirmed nursing staff did not notify the provider regarding the finding. During an interview on 7/6/26 at 12:40 p.m., a nurse practitioner (NP)-A stated she expected nursing staff to follow the facility's change in condition and		20900			08/05/2026	

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20900	Continued from page 7 wound care policies. NP-A stated nursing staff were required to notify the provider of a new skin impairment, depending on the resident diagnosis and condition. NP-A confirmed she was not notified regarding R1's left ankle PU. The facility Wound Care policy dated 9/1/2018 indicated if a resident is admitted with impaired skin integrity or a new pressure injury or lower extremity wound develops nursing staff implements the following item: Documentation of the skin impairment is completed in the medical record. Staging of Pressure Injury is completed as necessary by trained licensed associates. Standing orders/protocol for skin wound are initiated. Notify attending provider and resident representative. Attending provider determines wound type and may provide additional orders. Notify Supervisor/designee. Evaluate current pressure reduction interventions and revise resident centered care plan. When pressure injury is present, the dressing and/or wound is monitored, as appropriate. Weekly the licensed nurse will stage, measure, and examine the wound bed and the surrounding skin. If wound bed has deteriorated; notify provider. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review policies and procedures, educate staff, and implement measures to ensure residents are receiving the necessary services to prevent pressure ulcers or improve areas from occurring. The director of nursing or designee, could conduct random audits of the delivery of care, to ensure appropriate care and services are implemented to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20900			08/05/2026	
21385	Infection Control; Staff assistance CFR(s): MN Rule 4658.0800 Subp. 3		21385	Corrected		08/05/2026	

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21385	Continued from page 8 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This LICENSURE REQUIREMENT is NOT MET as evidenced by: The facility failed to ensure transmission-based precautions were followed for 2 of 4 (R2 and R3) residents observed for proper infection control practices. Findings include: R2 R2's Admission Record dated 7/12/2024, indicated R2's diagnoses included anoxic brain damage, tracheostomy (a surgically created opening in the front of the neck and directly into the windpipe), unspecified protein-calorie malnutrition, systemic inflammatory response syndrome (SIRS) and tube-feeding. R2's quarterly Minimum Data Set (MDS) dated 6/16/26, indicated R2 had severe cognitive impairment and required total extensive assistance of two persons with mechanical lift for transfers. R2's care plan dated 4/23/26, indicated R2 required Enhanced Barrier Precautions (EBP) related to aspiration pneumonia, chronic respiratory failure, and the presence of tracheostomy and gastrostomy tube. The care plan also indicated R2 was dependent on staff for toilet hygiene and transfers with staff interventions included posting clear signage on the door indicating the type of precautions and following EBP direction while providing high contact care activities. During an observation on 7/2/26 at 11:05 a.m., a nursing assistant (NA)-B and RN-A were observed transferring R2 whose room had EBP signage posted on the door. Neither NA-B nor RN-A donned a gown before providing care. NA-B removed the soiled bedding and made the bed without wearing a gown. After the transfer, NA-B picked up the soiled linen from the floor of the resident's room. RN-A parked the mechanical lift in the hallway after use without cleaning or disinfecting the equipment.			21385			08/05/2026

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21385	Continued from page 9 During an interview on 7/2/26 at 10:23 a.m. NA-B stated a gown, and gloves were expected to be worn during transfers for residents on EBP. NA-B confirmed he should have worn a gown and gloves while providing high contact care activity to R2. During an interview on 7/2/26 at 11:53 a.m., RN-A stated staff usually donned a gown during high-contact activities with R2. RN-A stated EBP signage directed staff on the appropriate PPE (Personal Protective Equipment) to wear based on the care being provided; however, he was unsure whether R2 was on EBP. RN-A confirmed he did not wear a gown while transferring R2 with the mechanical lift and forgot to disinfect the lift after use. RN-A stated the lift should be cleaned after each use to prevent cross-contamination. R3 R3's Admission Record dated 8/12/2020, indicated R3's diagnoses included traumatic subdural hemorrhage, chronic respiratory failure with hypoxia , tracheostomy, gastrostomy, osteomyelitis, and disruption of wound. R3's quarterly Minimum Data Set (MDS) dated 16/26/26, indicated R1 had severe cognitive impairment and required total extensive assistance of two persons with mechanical lift for transfers. R3's care plan dated 6/22/26 indicated R3 had gastrostomy-tube site and an open area on the abdomen , as well as tracheostomy. The care plan also indicated R3 was dependent on staff for toilet hygiene and transfers with staff interventions included monitor tube site for sign/symptoms of infection and reporting any concerns to the provider, as well as following EBP during high-contact care activities. During an observation on 7/1/26 at 12:01 p.m., NA-A exited R4's room which had EBP signage posted on the door, while still wearing a gown and gloves. Without removing the gown and gloves, NA-A entered R3's room to get a large brief and then returned to R4's room to continue providing care. During an interview on 7/1/26 at 12:27 p.m., NA-A stated she had received training regarding the facility's infection control protocols. NA-A stated she was providing bed toileting to R4 whose room had EBP signage posted on the door and needed a			21385			08/05/2026

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21385	Continued from page 10 clean brief. NA-A stated she obtained the brief from R3's room while still wearing a gown and gloves. NA-A stated she should have removed her gown and gloves before leaving R4's room to obtain supplies in order to prevent cross contamination. During an observation on 7/6/26 at 8:47 a.m., RN-E provided trach care and tube-feeding to R3 without wearing a gown. R3's room had EBP signage posted on the door directed staff to wear appropriate PPE. During an interview on 7/6/26 at 9:00 a.m., RN-E stated when a resident had tracheostomy and gastrostomy tube, staff should post EBP signage on the resident's door and follow the facility's infection protocols. RN-E confirmed she did not wear a gown while providing tracheostomy care and administering tube-feeding to R3. RN-E stated she knew the appropriate procedure and should have worn the required PPE to help prevent the transmission of infection. During an interview on 7/6/26 at 4:58 a.m., the director of nursing (DON) stated she expected all staff to be knowledgeable about EBP and to wear appropriate PPE when providing high-contact care to residents on EBP. The facility Enhanced Barrier Precaution policy dated 4/1/2024 indicated enhanced barrier precautions should be followed outside the resident's room when performing transfers and assisting during a high contact activity such as bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility, or any high-contact activities included dressing, transferring, changing linens, and device care or use such urinary catheters, feeding tubes, and tracheostomy. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.			21385			08/05/2026