Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 1, 2026

Administrator
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY
3815 WEST BROADWAY AVENUE
ROBBINSDALE, MN 55422

RE: CCN:245279
Cycle Start Date: May 14, 2026

Dear Administrator:

On May 14, 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:

Nikki Harvey, Regional Operations Supervisor, Rapid Response
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nikki.Harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 August 14, 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 November 14, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social

Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

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3815 WEST BROADWAY AVENUE
ROBBINSDALE, MN 55422

Re: State Nursing Home Licensing Orders
Event ID: 231F5A-H1

Dear Administrator:

The above facility survey was completed on May 14, 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:

Nikki Harvey, Regional Operations Supervisor, Rapid Response
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nikki.Harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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: 245279	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE , ROBBINSDALE, Minnesota, 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 5/13/26 and 5/14/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52791621C (2992414). As a result of the investigation deficiencies were cited at F550, F656, and F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		06/19/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the	F0550	R1 was discharged from facility at time of survey. All residents have the potential to be affected by this deficient practice. Facility staff interviewed residents and staff who provide care on this unit to ensure that care is being provided with dignity and respect. Anyone found to have been impacted received appropriate corrective actions using a person-centered approach. To ensure deficient practice will not recur, education on policies: Resident Dignity will be provided to all staff by the Director of Nursing Services or designee via in-person training by 6/19/2026 or prior to next working shift.	06/19/2026

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

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

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F0550 SS = D	Continued from page 1 resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, and document review, the facility failed to promote dignity while providing care for 1 of 3 residents (R1) reviewed who required assistance with activities of daily living. Findings include: R1's admission Minimum Data Set (MDS) dated 3/26/26, indicated R1 admitted to the facility on 3/20/26, was severely cognitively impaired, required staff assistance for transfers, and had diagnoses that included dementia. During an interview on 5/13/26 at 8:32 a.m., R1's family member (FM)-A stated she had a video of staff yelling at R1 when R1 asked for help. The FM-A stated R1 reported being upset after staff yelled at her. The FM-A did not understand why staff would yell at a resident with the diagnosis of dementia. The FM-A stated it was upsetting to see the video and further stated she wanted R1 cared for by people who wanted to help R1. The staff in the video did not seem like they wanted to help.	F0550	Continued from page 1 To ensure compliance is maintained, random audits of care interactions focused on resident dignity and rights will be completed by the Director of Nursing Services or designee weekly x 4 and monthly x 3 to ensure concerns are addressed timely. Results will be brought to the QAPI committee for further recommendations. Compliance date 6/19/2026.	06/19/2026

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F0550 SS = D	Continued from page 2 During an interview on 5/13/26 at 4:04 p.m., the nursing assistant (NA)-C stated staff should not call residents grandma or momma because it was not professional, and it was not allowed at the facility. Staff should instead call residents by their preferred name and should treat residents kindly. During an interview on 5/13/26 at 4:17 p.m., the registered nurse (RN)-B stated staff were supposed to be respectful and call resident's by their preferred name, not momma or grandma. During an observation with the administrator and the director of nursing (DON) on 5/14/26 at 11:00 a.m., review of a video from the camera in R1's room dated 4/3/26 at 7:54 p.m., revealed two staff talking to R1. The DON and administrator identified the staff in the video as NA-E and NA-E. NA-E told R1 she was asking for help for no reason, stated R1 was "cutting up" and it was the last time staff would be in the room. NA-E then addressed R1, "grandma." The DON stated staff should treat residents with respect. Also during the observation and review of a video from the camera in R1's room dated 4/3/26 at 8:14 p.m., revealed two staff, the NA-A and the NA-B, transferred R1 with a Stand Aid (device used to assist resident from sitting to standing position and from standing to sitting position). The DON and administrator acknowledged it was NA-A in the video and the NA-A who was standing in front of R1 during the transfer who encouraged R1 to sit. When R1 sat the NA-A stated, "There you go momma." During an interview on 5/14/26 at 1:46 p.m., the NA-B stated she had not worked with R1, even though she was identified by the administrator and DON in the video dated 4/3/26 at 8:14 p.m. During an interview on 5/14/26 at 1:48 p.m., the DON stated staff was expected to be respectful towards residents, the preferred name could be added to the care plan. Staff were not allowed to call residents grandma or momma because that was not respectful. The Resident Dignity policy dated 12/18/25 indicated staff would care for residents in a manner that maintained or enhanced each resident's dignity and respect and treat residents with respect and address each resident by their preferred name.	F0550		06/19/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F0656	R1 was discharged from facility at time of survey. All residents have the potential to be affected by this	06/19/2026

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F0656 SS = D	Continued from page 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 (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 interviews, observation, and document review the facility failed to implement care plan	F0656	Continued from page 3 deficient practice. To identify residents at potential risk, DNS or designee will observe residents requiring transfers using mechanical lift or stand aids according to care plans and ensure staff conduct transfers as care plan directs at time of observation. To ensure deficient practice will not recur, education on policies: Care Plans will be provided to all staff by the Director of Nursing Services or designee via in-person training by 6/19/2026 or prior to next working shift. To ensure compliance is maintained, the DNS/designee will complete random audits of resident transfer and cares weekly x 4 and monthly x 3. Results will be brought to the QAPI committee for further recommendations. Compliance date 6/19/2026.	06/19/2026

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F0656 SS = D	Continued from page 4 interventions for 1 of 3 residents (R1) when staff transferred R1 with pivot transfers (technique for moving a resident from one position to another. While standing, resident moves their feet to turn toward the new surface) instead of with the Stand Aid (non-motorized device to assist a person to a standing position), as indicated in the care plan. Findings include: R1's admission Minimum Data Set (MDS) dated 3/26/26 indicated R1 admitted to the facility on 3/20/26, was severely cognitively impaired, required staff assistance for transfers, and had diagnoses that included fractures, dementia and multiple traumas. R1's care plan dated 3/23/26 indicated R1 required assistance of one staff for toileting and transferred with a Stand Aid. During an interview on 5/13/26 at 8:32 a.m., R1's family member (FM)-A stated she was concerned about the way staff transferred R1. R1 was transferred by two people moving R1 instead of the machine [stand aid] staff were supposed to use. FM-A stated she had videos of R1's transfer from the toilet to the wheelchair, and from the wheelchair to the bed, indicating staff did not use the stand aid for transfers. During an interview on 5/13/26 at 3:56 p.m., the nursing assistant (NA)-D stated she did not recall how R1 was supposed to transfer, but staff would refer to the therapy book on the counter of the nurses' station to know how each resident was supposed to transfer. During an interview on 5/13/26 at 4:04 p.m., NA-C stated she was supposed to use the Stand Aid to transfer R1. The NA-C stated she always used the Stand Aid with R1 and did not transfer R1 without it because R1 could fall using a pivot transfer. During an interview on 5/13/26 at 4:44 p.m., the administrator stated R1's care plan indicated R1 required use of the stand aid and staff assistance for transfers. During an interview on 5/13/26 at 4:49 p.m., the registered nurse (RN)-A stated she did not remember R1. The RN-A stated a resident's care plan directed staff in how to transfer a resident safely and it was unsafe to transfer a resident with a pivot transfer instead of a Stand Aid if the therapy department directed staff to use a Stand Aid.	F0656		06/19/2026

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F0656 SS = D	Continued from page 5 During an interview on 5/14/26 at 10:13 a.m., the licensed practical nurse (LPN)-A stated when a resident's care plan indicated transfer with a Stand Aid, staff should transfer with a Stand Aid. R1 required the Stand Aid because she could not bear weight on both legs. During an observation with the physical therapy assistant (PTA)-A on 5/14/26 at 10:40 a.m., upon review of the video footage from the camera in R1's room, dated 4/4/26 at 8:17 p.m., revealed two staff pivot transferred R1 from the toilet to her wheelchair. The two staff did not use the Stand Aid. The PTA-A reviewed a second video dated 4/4/26 at 8:18 p.m., that revealed the same two staff transferred R1 from the wheelchair to R1's bed with a two-person pivot transfer instead of a Stand Aid. During an interview on 5/14/26 at 10:40 a.m., the PTA-A stated R1 was supposed to be transferred with a Stand Aid, and not with a two-person pivot transfer. The transfers on the video footage was not completed according to R1's care plan. Further, the PTA-A stated the therapy department kept a book at the nurses' station which gave direction how each resident was supposed to be transferred. The PTA-A stated R1 was supposed to transfer with the Stand Aid. During an observation with the administrator and clinical director (CD)-A on 5/14/26 at 11:00 a.m., upon review of the video dated 4/4/26 at 8:17 p.m., revealed two staff pivot-transferred R1 from the toilet to her wheelchair instead of using a Stand Aid. The administrator and CD-A reviewed a second video dated 4/4/26 at 8:18 p.m., that revealed the same two staff transferred R1 from the wheelchair to R1's bed with a two-person pivot transfer instead of a Stand Aid. During an interview on 5/14/26 at 11:00 a.m., the CD-A stated he did not see a Stand Aid in the videos. If the care plan indicated staff were supposed to use a Stand Aid, they should have used a Stand Aid for safety to ensure the resident did not fall. During an interview on 5/14/26 at 1:07 p.m., the director of nursing (DON) and administrator identified the staff from the two videos who transferred R1 from the toilet to the wheelchair and the wheelchair to the bed without a Stand Aid as NA-C and NA-D. During an interview on 5/14/26 at 1:34 p.m., the NA-A acknowledged she worked on 4/4/26 and	F0656		06/19/2026

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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
F0656 SS = D	Continued from page 6 assisted another staff to transfer R1 with a gait belt from the toilet to the wheelchair. The NA-A was aware R1's care plan indicated use the Stand Aid. The NA-A stated the Stand Aid was not used because R1 wanted to transfer with the gait belt instead. The NA-A stated she preferred to transfer residents with a pivot transfer and gait belt instead of using a Stand Aid, but sometimes R1 was able to stand and sometimes could not. R1 was not always able to remember to stand because R1 had dementia. The NA-A stated if the resident did not want to follow the care plan and use the Stand Aid, the NAs could talk to the nurse and use a two-person assist for transfers instead of following the care plan. During an interview on 5/14/26 at 1:49 p.m., NA-B stated she did not remember working with R1. To know how a resident was supposed to transfer, staff referred to the therapy book at the nurses' station or asked another staff who knew the resident. During an interview on 5/14/26 at 1:48 p.m., the DON stated R1 was supposed to transfer with a Stand Aid and one staff per R1's care plan. Therapy staff determined the residents' ability to transfer and put each resident's transfer status in the therapy book at the nurses' station. If a resident did not choose to follow the care plan the NA would ask a nurse for help to educate the resident about the risks and benefits of not following the care plan for safe transfers. When a resident has dementia, staff should attempt to perform the transfer according to the care plan for safety to prevent falls. The Care Plan for Therapy and Rehab policy dated 12/1/25 indicated the care plan used to provide guidance to the interdisciplinary team. The Safe Resident Handling Program (SRHP) policy dated 7/7/25 indicated the SRHP provided interventions to provide caregivers the guidance for type of equipment, type of size of sling, and number of people to safely complete mobility tasks. The Stand Aid was used for residents who demonstrated leg strength for weight-bearing and were able to hold their torso in an upright position and pull themselves to a standing position. The responsibility of the staff was to eliminate manual lifting whenever possible by utilizing equipment and safe lifting practices.	F0656		06/19/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F0689	R1 was discharged from facility at time of survey. All residents that transfer with assistance have the	06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245279	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2026

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F0689 SS = D	Continued from page 7 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observations, and document review the facility failed to ensure safe transfers for 1 of 3 residents (R1) who was lifted off the floor following a fall by two staff without using a Hoyer lift (mechanical lift used to transfer residents from one surface to another). In addition, two staff assisted R1 to stand from a wheelchair with a Stand Aid (non-motorized lift used to assist residents from a seated position to a standing position) without a gait belt. Findings include: R1's admission Minimum Data Set (MDS) dated 3/26/26, indicated R1 admitted to the facility on 3/20/26, was severely cognitively impaired, required staff assistance for transfers, and had diagnoses that included fractures and dementia. R1's care plan dated 3/23/26, indicated R1 required one staff to assist with toileting and transfers with a Stand Aid. During an interview on 5/13/26 at 8:32 a.m., R1's family member (FM)-A stated she was concerned staff were transferring R1 by two people moving R1 instead of the machine (Stand Aid) staff were supposed to use. The FM-A further stated she was concerned about how staff transferred R1 when they did use the Stand Aid because they did not have the required belt around R1 and pulled on R1's arms to get her out of the chair. FM-A stated she had videos of R1's transfers from the camera in R1's room. During an interview on 5/13/26 at 3:56 p.m., the nursing assistant (NA)-D stated she did not recall how R1 was supposed to transfer, but staff would refer to the therapy book on the counter of the nurses' station to know how each resident was supposed to transfer. The NA-D stated when a resident fell and an NA found the resident on the floor, the NA was supposed to get a nurse to assess	F0689	Continued from page 7 potential to be affected by this deficient practice. DNS or designee will observe residents requiring transfers using stand aid reviewing for gait belts use. DNS reviewed all residents who have had a fall within the last 14 days to ensure Hoyer lift was utilized when lifting resident off of the floor on 6/3/2026. If deficient practice found at observations, immediate correction was taken as appropriate. The policy: Safe Resident Handling Program (SRHP) was reviewed and determined appropriate. To ensure deficient practice will not recur, education on policies: Safe Resident Handling Program (SRHP) will be provided to all staff by the Director of Nursing Services or designee via in-person training by 6/19/2026 or prior to next working shift. This training includes how to assist residents from the floor following a fall. To ensure compliance is maintained, the DNS/designee will complete random audits of resident transfer and cares weekly x 4 and monthly x 3. Results will be brought to the QAPI committee for further recommendations. Compliance date 6/19/2026.	06/19/2026

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F0689 SS = D	Continued from page 8 the resident. If the resident was not injured the NA and the nurse would use a Hoyer lift to assist the resident from the floor. Staff used a Hoyer lift to prevent further injury and always used a Hoyer without exception. The NA-D did not recall helping R1. During an interview on 5/13/26 at 4:04 p.m., NA-C stated staff always used a Hoyer lift to assist residents off the floor after a fall. Staff could not lift the residents from the floor without a Hoyer lift, and a nurse had to be present. The NA-C stated she was supposed to use a Stand Aid to transfer R1. During an interview on 5/13/26 at 4:17 p.m., registered nurse (RN)-B stated after a resident fell, the nurses were supposed to assess the resident, take vital signs, perform neurological checks, and inform the resident's medical provider of the fall and assessment results. When a resident fell, the staff would use a Hoyer lift to get the resident off the floor, and staff were not allowed to just pick the resident up without the Hoyer lift. When staff utilized a Stand Aid for transfers, two staff were required, staff were supposed to use a gait belt around the resident for support as needed. Staff should not pull on the resident's hands or arms because it could injure the resident's shoulders. During a follow-up interview on 5/13/26 at 4:20 p.m., the NA-C stated she always used a Stand Aid with R1 and did not transfer R1 without it because R1 could fall. During an observation on 5/13/26 at 4:44 p.m. with the administrator and director of nursing (DON), of a video from the camera in R1's room, dated 3/30/26 at 8:17 p.m., two staff lifted R1 from the floor using R1’s arms, without a gait belt or Hoyer lift. During an interview on 5/13/26 at 4:44 p.m. the administrator identified the two staff who lifted R1 off the floor without a Hoyer lift as RN-A and NA-D. The DON was present during the interview and the administrator stated using a gait belt to get a resident off the floor would be best practice. The DON stated the facility recommended staff use a Hoyer to get residents off the floor. The administrator acknowledged she was not sure what the facility policy indicated for transfers off the floor, but would look. During an interview on 5/13/26 at 4:49 p.m., the registered nurse (RN)-A stated she did not remember R1. The RN-A stated when a resident was found on the floor, the nurse was expected to perform an	F0689		06/19/2026

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F0689 SS = D	Continued from page 9 assessment, and then if the resident was not injured, staff would assist the resident off the floor with a Hoyer lift for the safety of the resident, and to not cause injury. During a subsequent interview on 5/14/26 at 10:09 a.m., the administrator stated she incorrectly identified RN-A, but instead staff licensed practical nurse (LPN)-A assisted to lift R1 from the floor. During an interview on 5/14/26 at 10:13 a.m., the LPN-A stated when a resident was found on the floor, staff assisted the resident off the floor, “Per facility protocol.” The LPN-A stated when she found R1 on the floor, she called for NA-D to help. The LPN-A stated she followed facility protocol to assist the resident from the floor with another staff and a gait belt. The LPN-A stated during orientation she was trained to assist a resident off the floor with a Hoyer but used her nursing judgment to get R1 off the floor with a two-person assistance instead. During an observation with the physical therapy assistant (PTA)-A on 5/14/26 at 10:40 a.m. of the video from the camera in R1's room dated 3/30/26 at 8:17 p.m., PTA-A acknowledged staff assisted R1 off the floor with a two-person lift instead of with a Hoyer lift. Additionally, upon review of another video from the same camera dated 4/3/26 at 8:14 p.m., staff utilized a Stand Aid with R1 and did not use a gait belt around R1 to assist with a lift from the wheelchair to a standing position but should have. With the position of the resident on the Stand Aid, the resident could have fallen backwards and staff would not have been able to stop the fall without the gait belt. During an observation with the administrator and clinical director (CD)-A on 5/14/26 at 11:00 a.m., of the video from the camera in R1’s room dated 4/3/26 at 8:14 p.m., revealed staff transferred R1 with a Stand Aid without using a gait belt around R1, and staff used R1’s hands to pull R1 to a standing position. During an interview on 5/14/26 at 11:00 a.m., both the administrator and CD-A were present. The administrator acknowledged staff did not utilize a gait belt during the Stand Aid transfer, but should have. The CD-A acknowledged all nursing staff were trained about safe transfers and knew what they were supposed to do but had not performed R1's transfer from the chair safely and had not safely assisted R1 from the floor. During an interview on 5/14/26 at 1:07 p.m., the	F0689		06/19/2026

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F0689 SS = D	Continued from page 10 director of nursing (DON) and administrator identified the staff who transferred R1 without a gait belt on the Stand Aid as NA-A and NA-B. During an interview on 5/14/26 at 1:34 p.m., the nursing assistant (NA)-A stated staff were trained to use a gait belt around the resident's waist when using a Stand Aid. The NA-A stated she was not sure what other staff did, but she preferred to transfer R1 with a two-person, without the Stand Aid. When R1 declined to use a Stand Aid, the NA-A would tell the nurse and then used a two person transfer instead. The NA-A stated she just did what the resident wanted. Further, the NA-A stated sometimes R1 could help stand herself up, and sometimes she could not. The NA-A acknowledged R1 could not make decisions about her own safety due to her diagnosis of dementia. During an interview on 5/14/26 at 1:49 p.m., NA-B stated the correct way for staff to utilize a Stand Aid with a resident was to use a gait belt when assisting the resident to stand. During an interview on 5/14/26 at 1:48 p.m., the DON stated the facility policy indicated when a resident fell, staff would utilize a Hoyer lift if space allowed, and R1’s room contents could have been adjusted to allow for Hoyer use. When using a Stand Aid, staff were expected to use a gait belt around the waist of the resident so staff could help support the resident if the resident was unable to stand without assistance and to prevent falls. The Safe Resident Handling Program (SRHP) policy dated 7/7/25, indicated the SRHP provided interventions to provide caregivers the guidance for type of equipment, type of size of sling, and number of people to safely complete mobility tasks. The Stand Aid was used for residents who demonstrated leg strength for weight-bearing and were able to hold their torso in an upright position and pull themselves to a standing position. The responsibility of the staff was to eliminate manual lifting whenever possible by utilizing equipment and safe lifting practices.	F0689		06/19/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/13/26 and 5/14/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued: H52791621C (2992414).	20000		06/05/2026

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

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20000	Continued from page 1 As a result of the investigation a licensing order was issued at 0565. 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		06/05/2026
20565	Comprehensive Plan of Care; Use 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:	20565	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction	06/19/2026

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20565	Continued from page 2 Based on interviews, observation, and document review the facility failed to implement care plan interventions for 1 of 3 residents (R1) when staff transferred R1 with pivot transfers (technique for moving a resident from one position to another. While standing, resident moves their feet to turn toward the new surface) instead of with the Stand Aid (non-motorized device to assist a person to a standing position), as indicated in the care plan. Findings include: R1's admission Minimum Data Set (MDS) dated 3/26/26 indicated R1 admitted to the facility on 3/20/26, was severely cognitively impaired, required staff assistance for transfers, and had diagnoses that included fractures, dementia and multiple traumas. R1's care plan dated 3/23/26 indicated R1 required assistance of one staff for toileting and transferred with a Stand Aid. During an interview on 5/13/26 at 8:32 a.m., R1's family member (FM)-A stated she was concerned about the way staff transferred R1. R1 was transferred by two people moving R1 instead of the machine [stand aid] staff were supposed to use. FM-A stated she had videos of R1's transfer from the toilet to the wheelchair, and from the wheelchair to the bed, indicating staff did not use the stand aid for transfers. During an interview on 5/13/26 at 3:56 p.m., the nursing assistant (NA)-D stated she did not recall how R1 was supposed to transfer, but staff would refer to the therapy book on the counter of the nurses' station to know how each resident was supposed to transfer. During an interview on 5/13/26 at 4:04 p.m., NA-C stated she was supposed to use the Stand Aid to transfer R1. The NA-C stated she always used the Stand Aid with R1 and did not transfer R1 without it because R1 could fall using a pivot transfer. During an interview on 5/13/26 at 4:44 p.m., the administrator stated R1's care plan indicated R1 required use of the stand aid and staff assistance for transfers. During an interview on 5/13/26 at 4:49 p.m., the registered nurse (RN)-A stated she did not remember R1. The RN-A stated a resident's care plan directed staff in how to transfer a resident safely and it was	20565	Continued from page 2 constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. R1 was discharged from facility at time of survey. All residents have the potential to be affected by this deficient practice. To identify residents at potential risk, DNS or designee will observe residents requiring transfers using mechanical lift or stand aids according to care plans and ensure staff conduct transfers as care plan directs at time of observation. To ensure deficient practice will not recur, education on policies: Care Plans will be provided to all staff by the Director of Nursing Services or designee via in-person training by 6/19/2026 or prior to next working shift. To ensure compliance is maintained, the DNS/designee will complete random audits of resident transfer and cares weekly x 4 and monthly x 3. Results will be brought to the QAPI committee for further recommendations. Compliance date 6/19/2026.	06/19/2026

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20565	Continued from page 3 unsafe to transfer a resident with a pivot transfer instead of a Stand Aid if the therapy department directed staff to use a Stand Aid. During an interview on 5/14/26 at 10:13 a.m., the licensed practical nurse (LPN)-A stated when a resident's care plan indicated transfer with a Stand Aid, staff should transfer with a Stand Aid. R1 required the Stand Aid because she could not bear weight on both legs. During an observation with the physical therapy assistant (PTA)-A on 5/14/26 at 10:40 a.m., upon review of the video footage from the camera in R1's room, dated 4/4/26 at 8:17 p.m., revealed two staff pivot transferred R1 from the toilet to her wheelchair. The two staff did not use the Stand Aid. The PTA-A reviewed a second video dated 4/4/26 at 8:18 p.m., that revealed the same two staff transferred R1 from the wheelchair to R1's bed with a two-person pivot transfer instead of a Stand Aid. During an interview on 5/14/26 at 10:40 a.m., the PTA-A stated R1 was supposed to be transferred with a Stand Aid, and not with a two-person pivot transfer. The transfers on the video footage was not completed according to R1's care plan. Further, the PTA-A stated the therapy department kept a book at the nurses' station which gave direction how each resident was supposed to be transferred. The PTA-A stated R1 was supposed to transfer with the Stand Aid. During an observation with the administrator and clinical director (CD)-A on 5/14/26 at 11:00 a.m., upon review of the video dated 4/4/26 at 8:17 p.m., revealed two staff pivot-transferred R1 from the toilet to her wheelchair instead of using a Stand Aid. The administrator and CD-A reviewed a second video dated 4/4/26 at 8:18 p.m., that revealed the same two staff transferred R1 from the wheelchair to R1's bed with a two-person pivot transfer instead of a Stand Aid. During an interview on 5/14/26 at 11:00 a.m., the CD-A stated he did not see a Stand Aid in the videos. If the care plan indicated staff were supposed to use a Stand Aid, they should have used a Stand Aid for safety to ensure the resident did not fall. During an interview on 5/14/26 at 1:07 p.m., the director of nursing (DON) and administrator identified the staff from the two videos who transferred R1 from the toilet to the wheelchair and the wheelchair to the bed without a Stand Aid as NA-C and NA-D.	20565		06/19/2026

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20565	Continued from page 4 During an interview on 5/14/26 at 1:34 p.m., the NA-A acknowledged she worked on 4/4/26 and assisted another staff to transfer R1 with a gait belt from the toilet to the wheelchair. The NA-A was aware R1's care plan indicated use the Stand Aid. The NA-A stated the Stand Aid was not used because R1 wanted to transfer with the gait belt instead. The NA-A stated she preferred to transfer residents with a pivot transfer and gait belt instead of using a Stand Aid, but sometimes R1 was able to stand and sometimes could not. R1 was not always able to remember to stand because R1 had dementia. The NA-A stated if the resident did not want to follow the care plan and use the Stand Aid, the NAs could talk to the nurse and use a two-person assist for transfers instead of following the care plan. During an interview on 5/14/26 at 1:49 p.m., NA-B stated she did not remember working with R1. To know how a resident was supposed to transfer, staff referred to the therapy book at the nurses' station or asked another staff who knew the resident. During an interview on 5/14/26 at 1:48 p.m., the DON stated R1 was supposed to transfer with a Stand Aid and one staff per R1's care plan. Therapy staff determined the residents' ability to transfer and put each resident's transfer status in the therapy book at the nurses' station. If a resident did not choose to follow the care plan the NA would ask a nurse for help to educate the resident about the risks and benefits of not following the care plan for safe transfers. When a resident has dementia, staff should attempt to perform the transfer according to the care plan for safety to prevent falls. The Care Plan for Therapy and Rehab policy dated 12/1/25 indicated the care plan used to provide guidance to the interdisciplinary team. The Safe Resident Handling Program (SRHP) policy dated 7/7/25 indicated the SRHP provided interventions to provide caregivers the guidance for type of equipment, type of size of sling, and number of people to safely complete mobility tasks. The Stand Aid was used for residents who demonstrated leg strength for weight-bearing and were able to hold their torso in an upright position and pull themselves to a standing position. The responsibility of the staff was to eliminate manual lifting whenever possible by utilizing equipment and safe lifting practices.	20565		06/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/14/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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20565	Continued from page 5 SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are implemented for residents who require lifts for transfers. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	20565		06/19/2026