



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 4, 2025

Administrator
Flagstone
12500 CASTLEMOOR DRIVE
EDEN PRAIRIE, MN 55344

RE: CCN: 245312

Cycle Start Date: July 17, 2025

Dear Administrator:

On August 21, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 31, 2025

Administrator
Flagstone

12500 CASTLEMOOR DRIVE
EDEN PRAIRIE, MN 55344

RE: CCN:245312

Cycle Start Date: July 17, 2025

Dear Administrator:

On July 17, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

LeAnn Huseh, RN, Regional Operations Supervisor, Rapid Response
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseh@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 17, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 17, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies. A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,



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



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July 31, 2025

Administrator

Flagstone

12500 CASTLEMOOR DRIVE

EDEN PRAIRIE, MN 55344

Event ID: 1D101B-H1

Dear Administrator:

The above facility survey was completed on July 17, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER Flagstone			STREET ADDRESS, CITY, STATE, ZIP CODE 12500 CASTLEMOOR DRIVE , EDEN PRAIRIE, Minnesota, 55344	
(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
20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>On 7/17/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.</p> <p>The following complaint was reviewed:</p> <p>H53128208C (MN00114082) NO licensing orders were issued.</p>	20000		08/08/2025

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/17/2025
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20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/17/2025
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F0000	<p>INITIAL COMMENTS</p> <p>On 7/17/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed. H53128208C (MN00114082) with deficiencies issued at F658 and F880.</p> <p>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.</p> <p>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.</p>	F0000		08/08/2025
F0658 SS = E	<p>Services Provided Meet Professional Standards</p> <p>CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans</p> <p>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to ensure professional standards of practice were followed during medication administration for 5 of 5 residents (R1, R2, R4, R5, R6) observed for medication administration.</p> <p>Findings include:</p> <p>R1</p> <p>R1's annual Minimum Data Set (MDS) assessment dated 7/3/25, indicated she was cognitively intact and</p>	F0658	<p>This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report.</p> <p>On 8/4/2025 the Medication Administration Policy and Medication Administration Procedures were reviewed by the Administrator, Clinical Administrator and Clinical Coordinators.</p> <p>On 8/4/2025 R6's orders were clarified and instructions to mix 6oz of water with Miralax added.</p> <p>On 8/4/2025 Household Coordinators (HHC) completed a house wide audit to ensure no other medications were left in resident rooms. Any findings have been corrected.</p> <p>On 8/4/2025 Clinical Coordinators (CC) and Clinical Administrator (CA) generated an audit of all residents on Miralax and the orders were changed to mix with 6oz of water.</p>	08/15/2025

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0658 SS = E	<p>Continued from page 1 required moderate assistance in activities of daily living.</p> <p>R1's physician order from the medication administration record, dated 1/6/25, indicated "Ativan Oral Tablet 0.5 milligrams (Lorazepam). Give 0.5 milligrams by mouth every 6 hours as needed for panic attack.</p> <p>Camera footage dated 6/21/25 at 12:53 a.m., showed registered nurse (RN)-A entered R1's room with a medication cup and spoon. RN-A stated to R1, "I think you are describing a lot of tension. This will help, the lorazepam." R1 said "Is it like Ativan? I can't have that." RN-A stated the medication was the same as R1's gabapentin order, administered the medication to R1 and immediately left the room.</p> <p>On 7/17/25 at 9:00 a.m., trained medication aid (TMA)-A went to the medication cart and grabbed an already prepared cup of medications for R1. TMA-A gave R1 her medications one at a time, mixed in applesauce and with a spoon. TMA-A did not explain the purpose of all medications to R1.</p> <p>On 7/17/25 at 12:15 p.m., R1 was interviewed and stated not all staff stayed in the room to make sure she finished her medications.</p> <p>R2</p> <p>R2's quarterly MDS assessment dated 5/1/25, indicated she was cognitively intact and required moderate assistance in activities of daily living.</p> <p>On 7/17/25 at 10:18 a.m., R2 was interviewed and stated that not all staff wait for her to finish her medications before they left her room.</p> <p>R4</p> <p>R4's quarterly MDS assessment dated 6/5/25, indicated she was cognitively intact and required moderate assistance in activities of daily living.</p> <p>On 7/17/25 at 8:46 a.m., TMA-A was observed administering medications to R4. TMA-A administered the pills mixed in applesauce by spoon and handed her a cup of water after every spoonful. TMA-A did not explain what medications she was administering to R4.</p> <p>R5</p> <p>R5's quarterly MDS assessment dated 5/28/25, indicated she was cognitively intact and required moderate</p>	F0658	<p>Continued from page 1 On 8/4/2025 CC's and CA audited all medication carts to ensure carts were up to date with expiration dates. Any findings have been corrected. Also, an RN from Radius pharmacy audited 2/3 carts and any findings have been corrected.</p> <p>On 8/6 and 8/7 education provided to licensed nurses and TMA's regarding medication administration procedures, verifying expiration dates, raising the head of bed to 45 degrees while administering medications, explanation of medications while administering, and ensuring that residents are finishing medications before leaving the room.</p> <p>Education to be completed by 8/15/2025 for licensed staff and Trained Medication Administrators on following the 8 rights of medication administration. To ensure deficient practice will not recur, Clinical Coordinators will complete Medication Administration Audits, Medication Cart Audits, Medication Storage Audits weekly for one month and then monthly for 3 months. Trends will be reviewed at quarterly Quality Assurance (QA) meetings until 100% compliance has been determined by the QA team. The Director of Nursing/designee will be responsible for monitoring audits for compliance.</p>	

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F0658 SS = E	<p>Continued from page 2 assistance in activities of daily living.</p> <p>On 7/17/25 at 9:05 a.m., TMA-A started to prepare medications for R5, she did not verify the expiration dates for the medications. At 9:11 a.m., TMA-A stated she checked medication expiration dates when new medications arrived from the pharmacy and the nurses came around to check expiration dates.</p> <p>R6</p> <p>R6's quarterly MDS assessment dated 6/19/25, indicated she was moderately cognitively impaired and required substantial assistance in activities of daily living.</p> <p>R6's physician orders dated 7/17/25, included an order for Polyethylene Glycol 3350 powder (Miralax). Give 17 grams by mouth one time a day for constipation. It also included an order for Potassium Chloride extended-release oral tablet. Give 20 milliequivalent by mouth one time a day for malnutrition. The order lacked instructions to administer with any amount of water. R6's orders lacked a self-administration order allowing R6 to administer her medications independently.</p> <p>On 7/17/25 at 9:28 a.m., TMA-B was observed preparing medications for R6. TMA-B was not verifying medication expiration dates while going through each medication. TMA-B poured 17 grams of Miralax powder into a cup and mixed it with water, he also placed one Potassium Chloride tablet into the medication cup. At 9:40 a.m., TMA-B entered R6's room and R6 was laying at about a 30-degree angle in her bed, TMA-B did not raise the head of the bed prior to giving R6 her medications. R6 swallowed all of her pills at once and drank half of the cup of Miralax. TMA-B walked out of the room before verifying R6 finished the Miralax and the Miralax was left on the bedside table. TMA-B stated there was a staff person who came around and checked expiration dates about once per month.</p> <p>On 7/17/25 at 1:04 p.m., RN-A was interviewed and she stated that staff should inform residents what their medications were and what they were for during medication passes. Medication expiration dates should be checked before medications were administered. Staff should stand with the resident until all of the medications had been taken.</p> <p>On 7/17/25 at 1:38 p.m., RN-B was interviewed and stated staff should inform residents what medications they were receiving and what they were for. Medication expiration dates should be checked everyday. Staff</p>	F0658		

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F0658 SS = E	<p>Continued from page 3 should make sure residents drank everything and took all medications before staff left the room and document.</p> <p>On 7/17/25 at 2:04 p.m., TMA-B was interviewed and stated that it depended on the resident if the medications should be explained to them or not. Some residents did not care. Potassium chloride should be given with a full glass of water and if there was a medication mixed in with a glass of water, staff should ask residents to drink the full glass of water.</p> <p>On 7/17/25 at 2:20 p.m., a pharmacist was interviewed. She stated staff should follow doctors orders to mix the Miralax so if the directions state to mix 17 grams in 8 ounces of water, it would be expected that the patient would drink the full amount.</p> <p>On 7/17/25 at 3:25 p.m., the interim director of nursing (DON) was interviewed. She stated that if a resident asked, staff should explain their medications. Medication expiration dates should be checked with the medication pass during the rights and the three checks. Staff should stay with a resident until they drank the medication fully.</p> <p>The facility policy, Medication Administration Policy, last modified May 2021 directed that residents have the right to know why they were receiving the drug. All medications to be administered according to medication label instructions unless specifically ordered by a doctor. Expiration dates would be reviewed prior to administration of medication. During medication administration, hand washing would be completed when appropriate. Medications would not be left at the bedside unless resident had an order for self-administration and the care plan reflected the resident's ability.</p>	F0658		
F0880 SS = E	<p>Infection Prevention & Control</p> <p>CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control</p> <p>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.</p> <p>§483.80(a) Infection prevention and control program.</p>	F0880	<p>This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of/or agreement with the deficiencies or conclusions contained in the department inspection report.</p> <p>The facility has established and maintained 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.</p> <p>On 8/4/2025 the Hand Washing Policy, Medication Administration Policy and Medication Administration</p>	08/15/2025

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F0880 SS = E	<p>Continued from page 4 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must 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</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p>	F0880	<p>Continued from page 4 Procedures were reviewed by the Administrator, Clinical Administrator and Clinical Coordinators.</p> <p>On 8/4/2025 HHC did a house wide audit to ensure that every resident rooms had working hand sanitizers near the entrance of their door and in the bathroom. Any findings were sent to TELS work order to be fixed. On 8/6/2025 all sanitizers are properly working.</p> <p>On 8/6 and 8/7 education provided to licensed nurses and TMA's regarding proper hand hygiene.</p> <p>Education to be completed by 8/15/2025 for licensed staff and Trained Medication Administrators on Infection Control and Hand Hygiene. To ensure the deficient practice will not recur, Clinical Coordinators will complete Hand Hygiene audits weekly for one month and then monthly for 3 months. Trends will be reviewed at quarterly Quality Assurance (QA) meetings until 100% compliance has been determined by the QA team. The Director of Nursing/designee will be responsible for monitoring audits for compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245312	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER Flagstone			STREET ADDRESS, CITY, STATE, ZIP CODE 12500 CASTLEMOOR DRIVE , EDEN PRAIRIE, Minnesota, 55344	
(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
F0880 SS = E	<p>Continued from page 5</p> <p>§483.80(e) Linens.</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and document review, the facility failed to ensure hand hygiene was completed during medication administration for 5 of 5 residents (R1, R2, R4, R5, R6) observed for medication administration.</p> <p>Findings include:</p> <p>On 7/17/25 at 8:46 a.m., trained medication assistant (TMA)-A was observed administering medications to R4. TMA-A entered the room and touched R4, assisted her to stand up from her bed and then touched the resident's personal fridge to retrieve some apple sauce. TMA-A did not sanitize her hands before administering the medications to R4. TMA-A administered the medications mixed in applesauce by spoon and handed her a cup of water after every spoonful. After administering the medications, TMA-A used hand sanitizer but then touched her face. TMA-A returned to the medication cart and grabbed an already prepared cup of medications for R1. TMA-A did not sanitize her hands prior to entering R1's room at 8:54 a.m. TMA-A gave R1 her medications one at a time, mixed in applesauce and by spoon. TMA-A did not use hand sanitizer after administering the medications.</p> <p>On 7/17/25 at 9:28 a.m., TMA-B was observed preparing medications for R6. At 9:40 a.m., TMA-B entered R6's room without sanitizing his hands. After TMA-B administered R6's medications, hand sanitization was not completed.</p> <p>On 7/17/25 at 10:34 a.m., registered nurse (RN)-B was observed preparing medications for R2. RN-B was not observed completing hand hygiene prior to handling medications at the medication cart. RN-B brought the medications into R2's room for R2 to verify the medications per her preference. RN-B placed the medications into a med cup and handed the medications with a cup of water to R2, R2 finished her medications. RN-B left the room and did not complete hand</p>	F0880		

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F0880 SS = E	<p>Continued from page 6 sanitization.</p> <p>On 7/17/25 at 12:15 p.m., R1 was interviewed and stated she did not usually see staff completing hand hygiene before or after giving her medications.</p> <p>On 7/17/25 at 1:38 p.m., RN-B was interviewed and stated hand sanitizer should be used before and after medication passes.</p> <p>On 7/17/25 at 2:04 p.m., TMA-B was interviewed and stated that staff should sanitize their hands before and after medication administration.</p> <p>On 7/17/25 at 3:25 p.m., the interim director of nursing (DON) was interviewed. She stated hands should be sanitized between medication passes.</p> <p>The facility policy, Infection Control Standard Precautions, no revision date, directed staff that hand hygiene should be performed before and after contact with the resident, after contact with objects in the resident's room and before meals.</p>	F0880		