Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 26, 2026

Administrator
St. Benedicts Care Center
1810 Minnesota Boulevard Southeast
Saint Cloud, MN 56304

RE: CCN: 245350
Cycle Start Date: April 8, 2026

Dear Administrator:

On May 19, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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April 22, 2026

Administrator
St. Benedicts Care Center
1810 Minnesota Boulevard Southeast
Saint Cloud, MN 56304

RE: CCN: 245350
Cycle Start Date: April 8, 2026

Dear Administrator:

On April 8, 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 actual harm that was not immediate jeopardy (Level G), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other 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), 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)).

REMEDIES

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 8, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 8, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 8, 2026.

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

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

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

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

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/ Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 8, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor
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

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.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 8, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245350	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST BENEDICTS CARE CENTER	1810 MINNESOTA BOULEVARD SOUTHEAST , SAINT CLOUD, Minnesota, 56304

(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 4/7/26 through 4/8/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H53509802C (2967987) and a deficiency was issued at F689 at HARM PAST NON-COMPLIANCE. However, as a result of the investigation, a deficiency was cited at F880 . 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		05/08/2026
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility	F0689	"Past Noncompliance - no plan of correction required"	03/30/2026

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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F0689 SS = G	Continued from page 1 failed to follow manufacturer's recommendation and facility policy to ensure safe transfers with an EZ Way Smart Lift (mechanical, full body lift) for 1 of 3 resident (R1) reviewed for full body mechanical lift transfers. R1 fell out of the sling and sustained a laceration to his right eyebrow, was sent to the Emergency Department (ED), and required sutures. The facility implemented corrective action prior to the survey; therefore, the deficient practice was issued at past non-compliance. Findings included: R1's admission record dated 12/4/25, indicated R1's diagnoses included palliative care, wild-type transthyretin-related amyloidosis (build-up of abnormal proteins in tissues, such as heart and nerves), chronic kidney disease stage four (severe, irreversible loss of kidney function), and rhabdomyolysis (breakdown of skeletal muscle tissue). R1's care plan dated 12/4/2025, indicated R1 needed a full mechanical lift with assist of two staff for transfers. R1's significant change Minimum Data Set (MDS) dated 2/20/26, indicated R1 was cognitively intact, had no falls, and needed total assistance with transfers. R1's progress note dated 3/29/26 at 11:07 a.m., indicated at 9:14 a.m., staff was informed R1 was on the floor, licensed practical nurse (LPN)-A entered R1's room and R1 was on his right side and had a laceration approximately two inches above right eye. R1's progress note dated 3/29/26 at 12:36 p.m., indicated the ED nurse called the facility and stated R1's eyebrow laceration was deeper than they thought and needed multiple layers of dissolvable sutures due to laceration being the depth of the bone. R1's ED note dated 3/29/26, indicated R1 had a 5.0cm (centimeter) laceration to his right eyebrow after a fall from a mechanical lift. Was given oxycodone 10mg (milligram) and lidocaine-epinephrine (used to numb specific area) injection. R1 required 19 sutures placed in right eyebrow. During an interview on 4/8/26 at 12:12 p.m., nursing assistant (NA)-A stated on 3/29/26, she entered R1's room to assist NA-B with a full body lift transfer. NA-B had already hooked R1's sling to the	F0689		03/30/2026

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F0689 SS = G	Continued from page 2 lift. NA-A stated she did not double check to ensure R1's sling was attached to the lift correctly. NA-A stated that according to the policy she should have double checked the sling straps to ensure they were attached correctly but it, "slipped her mind." NA-A stated NA-B lifted R1 with the full body mechanical lift until he was no longer touching his wheelchair. NA-A pulled the wheelchair out from under R1 and R1 fell out of the lift when the right shoulder strap came off the lift. R1 fell on his right side and was bleeding from his right eyebrow. During an interview on 4/8/26 at 1:46 p.m., LPN-A stated on 3/29/26 around 9:00- 9:30 a.m., NA-B alerted LPN-A R1 had fallen and was on the floor. LPN-A went to R1's room and found him on the floor on his right-side bleeding from his right eye. LPN-A sent R1 into the ED. During an interview on 4/8/26 at 1:56 p.m., EZ Way representative stated she was aware of R1's fall from the lift. The expectation would be for staff to follow the instruction manual which included a final check to ensure all four loops were attached sufficiently to the respective hook of the hanger bar on the lift. If staff would have followed the manual and facility policy, R1's fall might have been prevented. During an interview on 4/8/26 at 2:21 p.m., the facility medical director stated if the staff had checked the straps per the policy they would have caught the issue and R1 would not have fallen and gotten injured. During an interview on 4/8/26 at 2:36 p.m., the director of nursing (DON) stated staff did not follow the process put into place and R1 fell from the lift due to the sling not being hooked to the lift correctly. The straps were not checked to ensure they were on the lift correctly by the second staff member. Facility policy, Using a Mechanical Lifting Machine revised 7/2017, indicated staff would attach sling straps according to manufacturer's instructions, would make sure the sling was securely attached to the hooks, before lifting the resident staff would double check the security of the sling attachment, examine all hooks, and would check the stability of the straps. EZ-Way Smart Life Operator's Instructions revised 2/10/2026, directed staff to make a final check of all four loop attachment points to ensure each loop was sufficiently attached to the correct hook of the	F0689		03/30/2026

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F0689 SS = G	Continued from page 3 hanger bar. The facility's corrective actions following this incident were confirmed through observation, interview, and record review of staff completing full body mechanical lift transfers with residents per policy and manufactures instructions, staffs ability to explain expectations of full body mechanical lift transfers, and review of re-education and audits completed with staff.	F0689		03/30/2026
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;	F0880	F0880 - During an observation on 4/7/26 at 12:45 p.m., nursing assistant (NA)-C and NA-D entered R1's room to transfer R1 from his wheelchair to another wheelchair for an appointment. R1 did not have signage or supplies for EBPs on his door or in his room. NA-C and NA-D did not have any EBPs (gown and gloves) on during R1's transfer. R1's lift sling was hooked to the full body mechanical lift. NA-C grabbed R1's catheter bag from under his wheelchair and attached it to the sling. R1 was placed in the new wheelchair and NA-D grabbed R1's catheter bag and attached it under the wheelchair. R1 was immediately placed on Enhanced Barrier Precautions (EBP). On 4/7, a comprehensive audit of all residents was conducted to ensure that appropriate precautionary measures were in place as indicated. Education on Enhanced Barrier Precautions, specifically regarding criteria for initiation, was provided to all nursing staff. Nursing staff are responsible for initiating precautions, while Clinical Managers are accountable for oversight of residents on precautions within their respective units. To prevent recurrence, residents on Enhanced Barrier Precautions will be audited weekly for three weeks, followed by monthly audits for an additional two months. Audit results will be reviewed at QA. The facility will be in compliance on 5/8/2026.	05/08/2026

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F0880 SS = D	Continued from page 4 (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 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: Based on observation, interview and document review, the facility failed to ensure staff consistently implemented enhanced barrier precautions (EBP) in accordance with Centers for Disease Control (CDC) guidelines to reduce the risk of infection spread for 1 of 3 residents (R1) reviewed for transfers. Findings include: R1’s admission record dated 12/4/25, indicated R1's diagnoses included benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms. R1’s care plan dated 3/4/26, indicated R1 had an indwelling foley catheter.	F0880		05/08/2026

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F0880 SS = D	Continued from page 5 R1's order summary report dated 3/4/26, indicated R1 had a foley catheter. During an observation on 4/7/26 at 12:45 p.m., nursing assistant (NA)-C and NA-D entered R1's room to transfer R1 from his wheelchair to another wheelchair for an appointment. R1 did not have signage or supplies for EBPs on his door or in his room. NA-C and NA-D did not have any EBPs (gown and gloves) on during R1's transfer. R1's lift sling was hooked to the full body mechanical lift. NA-C grabbed R1's catheter bag from under his wheelchair and attached it to the sling. R1 was placed in the new wheelchair and NA-D grabbed R1's catheter bag and attached it under the wheelchair. During an interview on 4/7/26 at 1:44 p.m., NA-C stated residents who have wounds or catheters should be on EBPs. R1 did have a foley catheter but NA-C was not sure why R1 was not on EBPs. The unit manager would decide who was on EBPs. NA-C did not wear EBPs when transferring R1 because R1 did not have the signage or supplies on his door and that is how NA-C would have known if someone was on EBPs. During an interview on 4/7/26 at 1:53 p.m., NA-D stated residents with open sores or catheters would have been on EBPs. R1 has a foley catheter. NA-D was not sure why R1 was not on EBPs as the nurse would decide who is placed on EBPs. NA-D did not use EBPs when transferring R1 because there was nothing on the door indicating NA-D needed to use EBPs. During an observation on 4/8/26 at 8:19 a.m., an EBP sign and personal protective equipment (PPE) was observed hanging on the outside of R1 room door. During an interview on 4/8/26 at 9:25 a.m., registered nurse (RN)-A stated R1 had a foley catheter and after clarification, R1 should have been on EBPs and was not until 4/7/26. RN-A stated she was the one responsible for putting signage on the resident's door and equipment outside the resident's room related to use of EBPs. During an interview on 4/8/26 at 2:36 p.m., the director of nursing (DON) stated RN-A would have been responsible for putting R1 on EBPs and was able to determine if a resident needed EBPs by following the facility policy. DON was not sure why R1 was not placed on EBPs prior to 4/7/26.	F0880		05/08/2026

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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
F0880 SS = D	Continued from page 6 The facility policy titled, Enhanced Barrier Precautions revised 12/2024, indicated EBPs would be applied when a resident had a wound or indwelling medical device. Indwelling medical devices include urinary catheters. Gowns and gloves would be applied when performing high contact resident activities including transfers.	F0880		05/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/08/2026**

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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 4/7/26 through 4/8/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure. The following complaints were reviewed during the survey. H53509802C (2967987). No licensing orders were written. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.	20000		03/30/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/08/2026**

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20000	Continued from page 1 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		03/30/2026