Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 18, 2025

Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

RE: CCN: 245376
Cycle Start Date: November 26, 2025

Dear Administrator:

On December 2, 2025, we notified you a remedy was imposed.

On December 16, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 4, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 26, 2026, did not go into effect. (42 CFR 488.417 (b))

In our letter of December 2, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 26, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on December 4, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 18, 2025

Administrator
Zumbrota Care Center
433 Mill Street
Zumbrota, MN 55992

Re: Reinspection Results
Event ID: 1D885B-H2

Dear Administrator:

On December 16, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 2, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

December 2, 2025

Administrator
Valley View Recovery Center
31591 64th Avenue
Cannon Falls, MN 55009

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID: FQ3211

Dear Administrator:

The above facility was surveyed on October 29, 2025 through October 29, 2025 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. 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 of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 Supervised Living Facilities.

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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is 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.

The first page of the state orders should be signed and submitted to:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, Minnesota 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

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 the supervisor listed above. A written plan for correction of licensing orders is not required.

Feel free to contact me with any questions related to this letter.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36336	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW RECOVERY CENTER	31591 64TH AVENUE CANNON FALLS, MN 55009

(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) COMPLETE DATE
5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, 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 or MN Statute indicated below. When a rule or statute 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. On 10/29/2025, surveyors of this Department's staff visited the above provider to determine compliance with the requirements of Minnesota Rules, Chapter 4665, requirements for Supervised Living Facilities (SLF). When corrections are completed, please sign and date on the bottom of the first page in the line marked with ...signature." Make a copy of these orders for your records and return the original to the address below email:	5 000		

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5 000	Continued From page 1 Jennifer Kolsrud, Supervisor email: jennifer.kolsrud@state.mn.us	5 000		
5 171	section 144.50, Subd. 6a Tuberculosis Prevention and Control (a) A supervised living facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the supervised living facility. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a two-step tuberculin skin test (TST), interferon-gamma release assay blood test (IGRA) and/or a chest x-ray (CXR) was completed for 3 of 3 employees (E-1, E-2, E-3) reviewed for tuberculosis (TB). This had the potential to affect all 48 residents residing in the facility.	5 171		

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5 171	Continued From page 2 Findings include: The undated employee listing identified E-1's date of hire was 6/15/24, E-2 date of hire was 9/3/25. E-3's date of hire was 10/3/24. Staff records for TB testing identified E-1TB testing was not completed, E-2 first step was completed on 9/2/25, no result was available and repeat testing was not completed. TB testing for E-3 was not completed. During an interview on 10/29/25 at 2:28 p.m., the treatment director (TD)-A stated E-1, E-2, and E-3 worked directly with clients, and it was expected first and second step TST's, blood test, or CXR would be completed upon hire to ensure their TB protection protocol was followed. TD-A confirmed E-1, E-2, and E-3 had not completed TB testing. The facility's policy titled Tuberculosis Infection Control Plan dated 6/1/2025, identified baseline TB testing was required for all new staff at the time of hire. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	5 171		
5 410	MN Rule 4665.3900 BED REST. Orders prescribing bed rest for residents shall be self-terminating in three days unless renewed by a physician. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a bed rest policy. This	5 410		

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5 410	Continued From page 3 had the potential to affect all 48 residents currently residing within the facility. Findings include: During policy review on 10/29/25, it was noted the facility policy and procedures provided lacked a policy for bed rest in the facility. During an interview on 10/29/25 at 2:28 p.m., the administrator confirmed the facility did not have a bed rest policy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 410		
5 515	MN Rule 4665.4700 FIRST AID. Every facility shall have on the premises a suitable first aid kit approved in writing by a physician for use for residents and staff. Tourniquets shall not be stored in the kit. The kit shall be maintained in a place known to and readily available to all personnel responsible for the health or well-being of residents, and such personnel shall be instructed in acceptable emergency first aid procedures. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure a tourniquet was not included in their first aid kit. The facility also failed to ensure the contents were approved in writing by a physician. This had the potential to affect all residents, staff, and visitors. Findings include:	5 515		

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5 515	Continued From page 4 During a facility tour and interview on 10/29/25 at 11:03 a.m., with the facility treatment director (TD)-A. A [brand name] first aid duffel bag was observed in the medication room. The kit contained varying sizes of gauze bandages, band aids, and other first aid items. A box containing tourniquets was also observed in the kit. This was verified by TD-A and licensed practical nurse (LPN)-A. The first aid kit did not contain an inventory list approved in writing by a physician. LPN-A stated she thought they had a policy stating approved contents of the first aid kit. TD-A stated each tech station also contained the same first aid kit. Both first aid kits contained tourniquets and lacked an inventory list signed by a physician. A first aid policy was requested but not received. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 515		
5 525	MN Rule 4665.4900 EMERGENCY PROCEDURES MEETING. There shall be a meeting of all employees on each shift at least once every three months to discuss emergency procedures used in the facility. Business of the meetings shall cover: A. assignment of persons to specific tasks and responsibilities in case of emergency situation; B. instructions relating to the use of alarm systems and signals; C. systems for notification of appropriate persons outside the facility; D. information on the location of emergency equipment in the facility; and E. specification of evacuation routes and	5 525		

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5 525	Continued From page 5 procedures. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to conduct quarterly emergency procedure meetings for all staff. This had the potential to affect all 48 clients resident at the facility, staff, and visitors. Findings include: During an interview on 10/29/25 at 2:31 p.m., the treatment director (TD)-A stated the facility staff are required to do online emergency preparedness training upon hire and annually however they do not do quarterly emergency procedure meetings with all staff. Individual policies titled "Fire Alarm and Fire Procedure", "Gas Leak or Loss of Electricity", and "Tornado or Natural Disaster", all dated 6/1/2025 indicated: "In accordance with Chapter 4664.4900, there shall be a meeting of all employees on each shift at least once every three months to discuss emergency procedures used in the facility. Business of the meetings shall cover: assignment of persons to specific tasks and responsibilities in case of emergency situation;, instructions relating to the use of alarm systems and signals, systems for notification of appropriate persons outside the facility, information on the location of emergency equipment in the facility, and specification of evacuation routes and procedures" TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 525		

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5 530	Continued From page 6	5 530		
5 530	MN Rule 4665.5000 TELEPHONES. There shall be at least one non-coin-operated telephone which is accessible to staff, residents, and visitors at all times for use in emergency. A list of the following telephone numbers shall be posted at this telephone: police, fire, ambulance, hospital, and emergency physician. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to post emergency numbers near telephones accessible to clients. This had the potential to affect all 48 clients who currently live in the facility. Findings include: During a physical plant tour on 10/29/25 at 11:03 a.m. with facility treatment director (TD)-A, a bank of telephones were observed available for resident's to use. No list of emergency contacts numbers were posted near the telephones. TD-A confirmed emergency numbers were not posted by the residents phone and stated facility staff had access to emergency numbers at the tech stations. TD-A verified tech stations are locked and not accessible to residents. An undated policy titled "Valley View Recovery Center client Guidelines and Expectations" mentioned telephone use expectations however did not mention reference to emergency numbers. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 530		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245376	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zumbrota Care Center	**433 MILL STREET , ZUMBROTA, Minnesota, 55992**

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F0000	INITIAL COMMENTS On 10/1/25 and 10/2/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H53764463C (2615914) with a deficiency issued at F689 and F690. 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		12/01/2025
F0689 SS = D	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 observation, interview, and document review the facility failed to comprehensively assess each fall to identify and analyze causal factors for potential root cause in order to determine individualized interventions to prevent or decrease the risk for future falls for 1 of 3 residents (R2) reviewed for falls.	F0689	POC F0689 Reviewed each fall from 10/1/25 to ensure every fall was comprehensively assessed 1. For R2 IDT comprehensively assessed R2 falls and reviewed current interventions and root cause analysis of falls. Updated care plan according to findings and educated staff on any revised or updated interventions. 2. Potential for all residents. Reviewed falls since October 1st to make sure they were comprehensively assessed and individualized interventions were put in place. 3. Reviewed fall prevention and management policy, no revisions needed. Staff educated on utilizing our post fall huddle papers and having post fall huddle meetings with all staff involved to better identify potential causes of falls and implement individualized interventions to decrease or prevent future falls.	12/01/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245376	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/26/2025

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F0689 SS = D	Continued from page 1 Findings include: R2's Fall Risk Evaluation dated 6/12/25, identified R2 had 1-2 falls in the past 3 months, had intermittent confusion, was ambulatory and continent. R2 had balance problem while standing and walking and required the use of assistive devices. R2 currently takes 3-4 high risk medications. R2 was at risk for falls, with a goal to be free of falls. Interventions: assist R2 with ambulation and transfers utilizing therapy recommendations, determine ability to transfer, and if fall occurs alert provider. R2's quarterly minimum data set (MDS) dated 9/10/25, identified R2's cognition was intact, and had diagnoses of Lewy body dementia (a progressive condition characterized by dementia, parkinsonism, and fluctuations in attention and alertness, along with other symptoms like hallucinations and problems with movement), non-Alzheimer's dementia, anxiety and diabetes. R2 required extensive assist of 1 person for transfers, toileting and toileting hygiene and was frequently incontinent of bladder and occasionally incontinent of bowel. R2 had one fall with no injury and 1 fall with injury. R2's care plan revised 4/25/25, identified a focus that R2 was at risk for falls related to gait, balance and cognition problems. History of falls with major injury, fracture of left hip requiring surgical interventions. Interventions revised on 4/10/25, directed staff to use a stationary nonreclining chair, be sure call light was in reach, Dycem placed on chair surface, use of a Reacher to help with prevention of falls, low pile mat under stationary chair and sign placed in room to remind to use call light to ask for assist. An additional focus revised 3/28/25, identified R2 was incontinent of bladder. Intervention dated 8/23/24, directed staff to monitor/document/report any possible causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects, clean peri area with each incontinent episode and use medium pull up brief, change daily and prn. Furthermore, an additional focus was revised 6/5/25, with activities of daily living (ADL) performance deficit related to disease process. Intervention dated 5/13/25, directed staff that R2 was assist of 1 with front wheeled walker in room for adl's and 8/15/25, identified R2 was 1 assist to the toilet.	F0689	Continued from page 1 4. Audits: DON or designee will complete fall audit 3 times a week x 2 weeks and 2 x a week for 2 weeks and then monthly after. Will review at QAPI for further recommendations. 5. Corrected by December 1st, 2025.	

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F0689 SS = D	Continued from page 2 R2's Fall incident report dated 9/5/25, identified at 2:30 p.m., another resident notified staff that R2 was on the floor. R2 was found face down on the floor next to his bed. R2's clothing was wet, and water was all over the floor. R2 sustained a skin tear to his right knee and knuckles on the right hand were red. R2 stated that he spilled a cup of water on the floor and was reaching forward out of his wheelchair to pick it up when he fell. Immediate action taken: R2 was placed back in his wheelchair per his request and silent alarm engaged. Reinforced the need to use call light. R2's Post Fall evaluation note dated 9/5/25 at 3:30 p.m., identified contributing factors of R2's fall was water was spilled on the floor and was incontinent at the time of the fall. R2's Fall progress note dated 9/5/25 at 4:00 p.m., identified root cause of fall was R2 spilled a cup of water on the floor and was reaching forward out of his wheelchair to pick it up. Intervention was a silent alarm was engaged, and writer reinforced the importance of using his call light when he needed assistance. R2's Fall interdisciplinary team (IDT) note dated 9/5/25 at 4:12 p.m., identified a root cause analysis that R2 dropped his water cup on the floor and reached forward in his wheelchair thinking he could pick it up off the floor. Intervention was R2's grippy socks were on and did not engage his call light. Follow up: signs were up in room to call for assistance and was wearing his call light. Encourage R2 to be out of his room and out in public spaces around others. Review of R2's record identified R2 was incontinent at the time of the fall on 9/5/25, needed assist with toileting, did not identify the last time R2 was toileted, no toileting care plan in place and toileting was not addressed. Furthermore, interventions the facility identified was a silent alarm, encourage to be out of his room and out in public spaces that were not updated to R2's care plan. R2's Fall Risk Evaluation dated 9/10/25, identified R2 had 1-2 falls in the past 3 months, had intermittent confusion, was chairbound and incontinent. R2 had gait/balance problem and required the use of assistive devices. R2 currently took 3-4 high risk medications within the last 7 days. R2 was at risk for falls, with a goal to be free of falls. Interventions: assist R2 with ambulation and transfers utilizing therapy recommendations and if resident was a fall risk initiate fall risk precaution. Clinical suggestion to	F0689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zumbrota Care Center	**433 MILL STREET , ZUMBROTA, Minnesota, 55992**

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F0689 SS = D	Continued from page 3 utilize a toileting program was left blank. R2's fall care plan was revised on 9/16/25 to include anti-tip bars on wheelchair however there was no corresponding assessment that identified why this intervention was implemented. R2's Fall incident report dated 9/23/25 at 6:20 p.m., identified R2 was found sitting on floor in the bathroom leaning backward in front of the toilet. R2 stated, "I was trying to do it by myself." Call light was not engaged. R2 had cut his right thumb and index finger. R2 assisted by using Hoyer lift into his bed. Resident offered complaints of back pain 6 out of 10, PRN (as needed) tramadol (pain med) received. Right thumb and index finger cleaned, steri strip applied, cover with gauze, and rolled gauze. Vital signs within normal limits. Resident Description: Self-transfer. R2 stated he tried to go to the bathroom by himself. Immediate action taken was R2 was assisted into his bed, reeducated on call light use and grippy socks were in place. R2's Fall progress note dated 9/23/25, identified the aforementioned information in addition to, an aide called for assistance in R2's room. Upon arrival R2 was found sitting on floor in the bathroom leaning backward in front of the toilet. Root cause was self-transfer. R2's Post Fall evaluation note dated 9/24/25, identified the fall on 9/23/25 with the aforementioned information. The note also included the contributing factors of this fall were R2 was incontinent at the time of the fall and diagnoses of Lewy bodies, dementia and Parkinson's does not allow R2 to make safe decisions. Root cause of fall was self-transfer. Intervention: R2 was reeducated on call light use and assisted into bed using a Hoyer lift. R2's Fall IDT note dated 9/24/25, identified R2 fell in his bathroom, Root cause analysis was R2 stated, " I wanted to do it myself," and unable to make safe decisions due to his dementia, parkinsonism and Lewy Bodies. Interventions: physical therapy occupational therapy (PT/OT) will work with him to build strength and safe transfers, and we will have the physician review his meds to see if anything needs to be removed or added. R2's progress note dated 9/25/25 at 9:48 p.m., identified R2 continued to demonstrate poor safety awareness, in addition to current fall precautions a cushioned floor mat was placed beside the bed on R2's exit side. The bed is on the lower position and locked,	F0689		

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F0689 SS = D	Continued from page 4 call light within reach. R2 denied having pain or discomfort this evening. Review of R2's record identified although the fall record identified causal factors of self-transfer and R2 was incontinent at the time of the fall on 9/23/25, there was no indication a comprehensive assessment to determine individualized interventions was completed to negate R2's risk of falls related to self-transfers due to needing to use the bathroom. In addition, the care plan was not updated to reflect a low bed or floor mat. R2's Fall progress note dated 9/28/25, identified another resident alerted staff that R2 was on the floor in his room on his knees. R2 was trying to get back in his recliner and was visibly upset about the situation. Root cause was R2 wanted to sit in his recliner, intervention was to remind to use the call light, so he does not get hurt. No injury noted with fall. Intervention was frequent checks completed on R2 throughout the evening. R2's Fall incident report for 9/28/25 was not found in R2's medical record. R2's Fall IDT note dated 9/29/25, identified R2 had a fall in his room on 9/28/25 at 6:15 p.m. Root cause analysis identified potential diagnoses that could have contributed to fall are recent fractured left femur, dementia, parkinsonism, Lewy body dementia, low back pain due to spinal stenosis/lumbar, chronic pain, orthostatic hypotension, history of falling, weakness, and major depressive disorder. Care plan was reviewed with current fall interventions in place, most recent was 6/10/25, anti-tip bars on wheelchair. Interventions pending lab results including urinalysis to guide any additional interventions. Potential interventions include bilateral lower extremity wraps to support blood pressure, obtain ortho blood pressures, place non-slip strips next to bed and in front of toilet, IDT review will convene following test results to determine specific intervention. In review of R2's record there is no indication an intervention was developed and implemented that mitigated the risk of falls based on the identified root cause of R2 independently transferring to his recliner. Furthermore, there was no indication the care plan was updated to include interventions of frequent checks, non-slip strips next to the bed and in front of the toilet. During an observation and interview on 10/2/25 at 9:10 a.m., R2 was seated in his recliner with his front	F0689		

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F0689 SS = D	Continued from page 5 wheeled walker within reach. R2 stated he needed help getting to the bathroom so he would not fall. R2 did not always make it to the bathroom in time and had accidents because staff did not always offer to help him to the bathroom. Staff had put a sign in his room to remind him to call for help but did not always remember to look at the sign to call for help. During an interview on 10/2/25 at 1:43 p.m., nursing assistant (NA)-A stated R2 was incontinent of bladder most days. NA-A reviewed R2's Kardex and stated he did not have a toileting care plan, but he should because he needs assist of 1 with toileting and has a history of falling. R2 had diagnosis of Lewy bodies so he did get more confused in the evenings, sometimes had delusions, and did not always remember to use his call light to ask for help with toileting which could lead to him falling. During an interview on 10/2/25, at 2:14 p.m., nurse manager (NM)-A stated two of R2's last three falls identified he was incontinent at the time of the fall and toileting was not addressed and should have been. NM-A stated R2 did not currently have a toileting plan in place but should due to his incontinence and the need for assist with toileting and transfers. NM-A stated each fall should be thoroughly investigated to determine a root cause to ensure the appropriate fall prevention plan is updated to the care plan to direct staff to prevent future falls. NM-A stated R2's last fall was not thoroughly investigated, there was no incident report filled out and there was no post fall incident completed to determine a root cause analysis and there was no new intervention for fall prevention put in place. Facility policy, "Fall Prevention and Management," reviewed 6/5/23, POLICY: The care center will assess each resident for risk of falls and identify interventions to assist in preventing falls and/or injuries. PURPOSE: To provide guidance to care center staff on assessing, identifying, and managing care for those residents at risk for falls. PROCEDURE: The care center will assess each resident's risk for falls at move in, quarterly and with any significant change in condition and will identify interventions to help prevent falls and/or to prevent injuries from falls… D. Post Fall Assessment: If a fall occurs while the individual is residing in the care center (or off premises on a care center specific activity) staff will perform the incident fall tracking assessment. a. Nursing staff will complete a fall scene investigation, assess the resident, and call for any additional assistance or 911 as necessary. b. An immediate	F0689		

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F0689 SS = D	Continued from page 6 intervention will be put into place, according to the immediate determination of the potential root cause of the fall, to prevent further falls until the root cause analysis (RCA) of the incident is completed. c. Nursing staff will document the fall by completing an Incident Report in the electronic medical record. From the immediate assessment of the incident, a determination will be made if the incident involved any maltreatment and/or serious bodily injury. If so, administrative staff will be notified, and a report of the incident will be sent to the State agency… e. The interdisciplinary team (IDT) will evaluate the fall by reviewing the fall incident report to determine a Root Cause Analysis (RCA) of the fall and further interventions may be put into place according to the determined cause of the fall, to help prevent further falls. Any further interventions that are developed will be documented…	F0689		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence,	F0690	POC F0690 Reviewed R2 3-day bowel and bladder diary and created an individualized toileting care plan. Potential for all residents. Reviewed bowel and blader comprehensive assessments and care plans to ensure residents have toileting plans in place. Reviewed Bowel and bladder policy, no revisions needed. Education provided to Nurse manager/ADON about bowel and bladder policy and comprehensive assessments. Audits will be completed 3 times per week x 2 weeks, and 2x per week for 2 weeks, then monthly after that. Audits focused on completion of bowel and bladder comprehensive assessments, ensuring completion on new admissions and ARD dates on a quarterly basis. Will review at QAPI for further recommendations. Corrected by December 1st, 2025.	12/01/2025

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F0690 SS = D	Continued from page 7 based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to develop an individualized toileting program to maintain or improve bowel/bladder continence for 1 of 3 residents (R2) reviewed for falls. Findings include R2's quarterly minimum data set (MDS) dated 9/10/25, identified R2's cognition was intact, and had diagnoses of Lewy body dementia (a progressive condition characterized by dementia, parkinsonism, and fluctuations in attention and alertness, along with other symptoms like hallucinations and problems with movement), non-Alzheimer's dementia, anxiety and diabetes. R2 required extensive assist of 1 person for transfers, toileting and toileting hygiene and was frequently incontinent of bladder and occasionally incontinent of bowel. In review of R2's record there was no indication a comprehensive bowel and bladder assessment was completed. R2's care plan revised 6/5/25, identified a focus with activities of daily living (ADL) performance deficit related to disease process. Goal revised 8/5/25, identified to improve current level of function through the review date, will be back to baseline and assist with adl's. Intervention dated 5/13/25, assist of 1 with front wheeled walker in room for adl's and 8/15/25, identified R2 was 1 assist to the toilet. An additional focus revised 3/28/25, identified R2 was incontinent of bladder. Goal revised 8/8/25, identified R2 will remain free from skin breakdown due to incontinence and brief use through the review date. Intervention dated 8/23/24, identified to monitor/document/report any possible causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects, clean peri area with each incontinent episode and use medium pull up brief, change daily and prn. R2's care plan did not include and individualized toileting schedule/program.	F0690		

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F0690 SS = D	Continued from page 8 During an observation and interview on 10/2/25 at 9:10 a.m., R2 was seated in his recliner and had his front wheeled walker within reach. R2 stated he needed help getting to the bathroom, so he doesn't fall. R2 did not always get to the bathroom in time and would have accidents because staff did not always offer to help him to the toilet. R2 stated staff put this a sign on his dresser to remind him to call for help so he doesn't fall, but he did not always remember to look at the sign to ask for help. R2 explained that it's difficult to remember to look for a sign and press the help button when you instinctively assume you can do things on your own. During an interview on 10/2/25 at 1:43 p.m., nursing assistant (NA)-A stated R2 was incontinent of bladder most days. NA-A reviewed R2's kardex and stated he did not have a toileting care plan, but he should because he needs assist of 1 with toileting and has a history of falling. R2 did get more confused in the evenings, sometimes had delusions, and did not always remember to use his call light to ask for help with toileting. During an interview on 10/2/25, at 2:14 p.m., nurse manager (NM)-A stated R2 did not currently have a toileting plan in place but should have one due to his incontinence and the need for assist with toileting and transfers. NM-A was unable to articulate a treatment and service plan to improve or maintain bowel and bladder. NM-A stated the facility "did not really" have a process in place for a personalized toileting plan and indicated they need to develop one. Facility policy titled, "Urinary Incontinence Program," reviewed 4/16/15, identified POLICY: St. Francis Health Services of Morris, Inc. (SFHS) provides care to those residents who are incontinent that will restore normal bladder and bowel function to the greatest extent possible, or at least prevent related incontinence complications. PURPOSE: Each resident who is incontinent will be identified, assessed, and provided appropriate care and services to achieve or maintain their greatest level of continence. Each resident will receive the appropriate care and services to prevent incontinence related complications to the extent possible… PROCEDURE: A. Each resident will be evaluated upon admission. The evaluation will include completion of a baseline review of the resident's elimination status. A comprehensive assessment, which will include a three (3) day bowel and bladder pattern assessment, will be completed within the initial assessment period. a. Based on the initial urinary incontinence or bowel incontinence history reported by the resident and/or family member(s), the new resident will be assisted in	F0690		

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F0690 SS = D	Continued from page 9 using incontinence products provided by the care center. Measurements of the resident, pattern of reported incontinence, incontinence product protocols for product use, and resident choice will be considered in the choice of incontinence product(s). b. The 3-day bowel and bladder pattern assessment will be completed and documented in hourly increments. A component of the three (3) day bowel and bladder pattern assessment may include bladder ultrasound equipment use. c. The comprehensive bowel and bladder assessment will include a report of prior incontinence history, a physical examination, documentation of genitourinary tract anomalies, results of the three (3) day bowel and bladder pattern, a review of diagnoses and medications that may impact urinary or bowel status, food and fluid intake patterns, environmental concerns as well as the consideration of adaptive devices, review of potential or existing complications of incontinence, and the resident's level of need for assistance due to physical or cognitive impairments. This assessment will be used to determine an individualized bowel and bladder program for each resident. "Bowel and Bladder Policy," revised 8/2023, indicated each resident receives the necessary care and service to attain or maintain the highest practicable level of bowel and bladder continence…2. The comprehensive assessment results are used to develop a care plan addressing the individual needs of each resident. Care plan interventions are determined with consideration of: a. the ability of the resident to make decisions and call for assistance to use the toilet. B. The presence of permanent physical impairment or disease which could prevent incontinence. C. Resident's desire to participate in bowel and bladder programing. D. current standards of practice in accordance with state and federal law. 3. Review of the comprehensive assessment and care plan will occur on at least a quarterly basis and more frequently if there is a change in residents' condition…	F0690		

Minnesota State Department of Health

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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 10/1/25 and 10/2/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		11/28/2025

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

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20000	Continued from page 1 The following complaints were reviewed. H53764463C (2615914) with a licensing order issued at 0830. 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		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the	20830	Completion date 12/1/25	12/01/2025

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20830	Continued from page 2 resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess each fall to identify and analyze causal factors for potential root cause in order to determine individualized interventions to prevent or decrease the risk for future falls for 1 of 3 residents (R2) reviewed for falls. Findings include: R2's Fall Risk Evaluation dated 6/12/25, identified R2 had 1-2 falls in the past 3 months, had intermittent confusion, was ambulatory and continent. R2 had balance problem while standing and walking and required the use of assistive devices. R2 currently takes 3-4 high risk medications. R2 was at risk for falls, with a goal to be free of falls. Interventions: assist R2 with ambulation and transfers utilizing therapy recommendations, determine ability to transfer, and if fall occurs alert provider. R2's quarterly minimum data set (MDS) dated 9/10/25, identified R2's cognition was intact, and had diagnoses of Lewy body dementia (a progressive condition characterized by dementia, parkinsonism, and fluctuations in attention and alertness, along with other symptoms like hallucinations and problems with movement), non-Alzheimer's dementia, anxiety and diabetes. R2 required extensive assist of 1 person for transfers, toileting and toileting hygiene and was frequently incontinent of bladder and occasionally incontinent of bowel. R2 had one fall with no injury and 1 fall with injury. R2's care plan revised 4/25/25, identified a focus that R2 was at risk for falls related to gait, balance and cognition problems. History of falls with major injury, fracture of left hip requiring surgical interventions. Interventions revised on 4/10/25, directed staff to use a stationary nonreclining chair, be sure call light was in reach, Dycem placed on chair surface, use of a Reacher to help with prevention of falls, low pile mat under stationary chair and sign placed in room to remind to use call light to ask for assist. An additional focus revised 3/28/25, identified R2 was incontinent of bladder. Intervention dated 8/23/24, directed staff to monitor/document/report any possible causes of incontinence: bladder infection,	20830		

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20830	Continued from page 3 constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects, clean peri area with each incontinent episode and use medium pull up brief, change daily and prn. Furthermore, an additional focus was revised 6/5/25, with activities of daily living (ADL) performance deficit related to disease process. Intervention dated 5/13/25, directed staff that R2 was assist of 1 with front wheeled walker in room for adl's and 8/15/25, identified R2 was 1 assist to the toilet. R2's Fall incident report dated 9/5/25, identified at 2:30 p.m., another resident notified staff that R2 was on the floor. R2 was found face down on the floor next to his bed. R2's clothing was wet, and water was all over the floor. R2 sustained a skin tear to his right knee and knuckles on the right hand were red. R2 stated that he spilled a cup of water on the floor and was reaching forward out of his wheelchair to pick it up when he fell. Immediate action taken: R2 was placed back in his wheelchair per his request and silent alarm engaged. Reinforced the need to use call light. R2's Post Fall evaluation note dated 9/5/25 at 3:30 p.m., identified contributing factors of R2's fall was water was spilled on the floor and was incontinent at the time of the fall. R2's Fall progress note dated 9/5/25 at 4:00 p.m., identified root cause of fall was R2 spilled a cup of water on the floor and was reaching forward out of his wheelchair to pick it up. Intervention was a silent alarm was engaged, and writer reinforced the importance of using his call light when he needed assistance. R2's Fall interdisciplinary team (IDT) note dated 9/5/25 at 4:12 p.m., identified a root cause analysis that R2 dropped his water cup on the floor and reached forward in his wheelchair thinking he could pick it up off the floor. Intervention was R2's grippy socks were on and did not engage his call light. Follow up: signs were up in room to call for assistance and was wearing his call light. Encourage R2 to be out of his room and out in public spaces around others. Review of R2's record identified R2 was incontinent at the time of the fall on 9/5/25, needed assist with toileting, did not identify the last time R2 was toileted, no toileting care plan in place and toileting was not addressed. Furthermore, interventions the facility identified was a silent alarm, encourage to be out of his room and out in public spaces that were not	20830		

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20830	Continued from page 4 updated to R2's care plan. R2's Fall Risk Evaluation dated 9/10/25, identified R2 had 1-2 falls in the past 3 months, had intermittent confusion, was chairbound and incontinent. R2 had gait/balance problem and required the use of assistive devices. R2 currently took 3-4 high risk medications within the last 7 days. R2 was at risk for falls, with a goal to be free of falls. Interventions: assist R2 with ambulation and transfers utilizing therapy recommendations and if resident was a fall risk initiate fall risk precaution. Clinical suggestion to utilize a toileting program was left blank. R2's fall care plan was revised on 9/16/25 to include anti-tip bars on wheelchair however there was no corresponding assessment that identified why this intervention was implemented. R2's Fall incident report dated 9/23/25 at 6:20 p.m., identified R2 was found sitting on floor in the bathroom leaning backward in front of the toilet. R2 stated, "I was trying to do it by myself." Call light was not engaged. R2 had cut his right thumb and index finger. R2 assisted by using Hoyer lift into his bed. Resident offered complaints of back pain 6 out of 10, PRN (as needed) tramadol (pain med) received. Right thumb and index finger cleaned, steri strip applied, cover with gauze, and rolled gauze. Vital signs within normal limits. Resident Description: Self-transfer. R2 stated he tried to go to the bathroom by himself. Immediate action taken was R2 was assisted into his bed, reeducated on call light use and grippy socks were in place. R2's Fall progress note dated 9/23/25, identified the aforementioned information in addition to, an aide called for assistance in R2's room. Upon arrival R2 was found sitting on floor in the bathroom leaning backward in front of the toilet. Root cause was self-transfer. R2's Post Fall evaluation note dated 9/24/25, identified the fall on 9/23/25 with the aforementioned information. The note also included the contributing factors of this fall were R2 was incontinent at the time of the fall and diagnoses of Lewy bodies, dementia and Parkinson's does not allow R2 to make safe decisions. Root cause of fall was self-transfer. Intervention: R2 was reeducated on call light use and assisted into bed using a Hoyer lift. R2's Fall IDT note dated 9/24/25, identified R2 fell in his bathroom, Root cause analysis was R2 stated, " I wanted to do it myself," and unable to make safe	20830		

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20830	Continued from page 5 decisions due to his dementia, parkinsonism and Lewy Bodies. Interventions: physical therapy occupational therapy (PT/OT) will work with him to build strength and safe transfers, and we will have the physician review his meds to see if anything needs to be removed or added. R2's progress note dated 9/25/25 at 9:48 p.m., identified R2 continued to demonstrate poor safety awareness, in addition to current fall precautions a cushioned floor mat was placed beside the bed on R2's exit side. The bed is on the lower position and locked, call light within reach. R2 denied having pain or discomfort this evening. Review of R2's record identified although the fall record identified causal factors of self-transfer and R2 was incontinent at the time of the fall on 9/23/25, there was no indication a comprehensive assessment to determine individualized interventions was completed to negate R2's risk of falls related to self-transfers due to needing to use the bathroom. In addition, the care plan was not updated to reflect a low bed or floor mat. R2's Fall progress note dated 9/28/25, identified another resident alerted staff that R2 was on the floor in his room on his knees. R2 was trying to get back in his recliner and was visibly upset about the situation. Root cause was R2 wanted to sit in his recliner, intervention was to remind to use the call light, so he does not get hurt. No injury noted with fall. Intervention was frequent checks completed on R2 throughout the evening. R2's Fall incident report for 9/28/25 was not found in R2's medical record. R2's Fall IDT note dated 9/29/25, identified R2 had a fall in his room on 9/28/25 at 6:15 p.m. Root cause analysis identified potential diagnoses that could have contributed to fall are recent fractured left femur, dementia, parkinsonism, Lewy body dementia, low back pain due to spinal stenosis/lumbar, chronic pain, orthostatic hypotension, history of falling, weakness, and major depressive disorder. Care plan was reviewed with current fall interventions in place, most recent was 6/10/25, anti-tip bars on wheelchair. Interventions pending lab results including urinalysis to guide any additional interventions. Potential interventions include bilateral lower extremity wraps to support blood pressure, obtain ortho blood pressures, place non-slip strips next to bed and in front of toilet, IDT review will convene following test results to determine specific intervention.	20830		

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20830	Continued from page 6 In review of R2's record there is no indication an intervention was developed and implemented that mitigated the risk of falls based on the identified root cause of R2 independently transferring to his recliner. Furthermore, there was no indication the care plan was updated to include interventions of frequent checks, non-slip strips next to the bed and in front of the toilet. During an observation and interview on 10/2/25 at 9:10 a.m., R2 was seated in his recliner with his front wheeled walker within reach. R2 stated he needed help getting to the bathroom so he would not fall. R2 did not always make it to the bathroom in time and had accidents because staff did not always offer to help him to the bathroom. Staff had put a sign in his room to remind him to call for help but did not always remember to look at the sign to call for help. During an interview on 10/2/25 at 1:43 p.m., nursing assistant (NA)-A stated R2 was incontinent of bladder most days. NA-A reviewed R2's Kardex and stated he did not have a toileting care plan, but he should because he needs assist of 1 with toileting and has a history of falling. R2 had diagnosis of Lewy bodies so he did get more confused in the evenings, sometimes had delusions, and did not always remember to use his call light to ask for help with toileting which could lead to him falling. During an interview on 10/2/25, at 2:14 p.m., nurse manager (NM)-A stated two of R2's last three falls identified he was incontinent at the time of the fall and toileting was not addressed and should have been. NM-A stated R2 did not currently have a toileting plan in place but should due to his incontinence and the need for assist with toileting and transfers. NM-A stated each fall should be thoroughly investigated to determine a root cause to ensure the appropriate fall prevention plan is updated to the care plan to direct staff to prevent future falls. NM-A stated R2's last fall was not thoroughly investigated, there was no incident report filled out and there was no post fall incident completed to determine a root cause analysis and there was no new intervention for fall prevention put in place. Facility policy, "Fall Prevention and Management," reviewed 6/5/23, POLICY: The care center will assess each resident for risk of falls and identify interventions to assist in preventing falls and/or injuries. PURPOSE: To provide guidance to care center staff on assessing, identifying, and managing care for	20830		

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20830	Continued from page 7 those residents at risk for falls. PROCEDURE: The care center will assess each resident's risk for falls at move in, quarterly and with any significant change in condition and will identify interventions to help prevent falls and/or to prevent injuries from falls… D. Post Fall Assessment: If a fall occurs while the individual is residing in the care center (or off premises on a care center specific activity) staff will perform the incident fall tracking assessment. a. Nursing staff will complete a fall scene investigation, assess the resident, and call for any additional assistance or 911 as necessary. b. An immediate intervention will be put into place, according to the immediate determination of the potential root cause of the fall, to prevent further falls until the root cause analysis (RCA) of the incident is completed. c. Nursing staff will document the fall by completing an Incident Report in the electronic medical record. From the immediate assessment of the incident, a determination will be made if the incident involved any maltreatment and/or serious bodily injury. If so, administrative staff will be notified, and a report of the incident will be sent to the State agency… e. The interdisciplinary team (IDT) will evaluate the fall by reviewing the fall incident report to determine a Root Cause Analysis (RCA) of the fall and further interventions may be put into place according to the determined cause of the fall, to help prevent further falls. Any further interventions that are developed will be documented… SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents, and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		

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F0000	INITIAL COMMENTS On 10/1/25 and 10/2/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H53764463C (2615914) with a deficiency issued at F689 and F690. 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		
F0689 SS = D	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 observation, interview, and document review the facility failed to comprehensively assess each fall to identify and analyze causal factors for potential root cause in order to determine individualized interventions to prevent or decrease the risk for future falls for 1 of 3 residents (R2) reviewed for falls.	F0689		

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 = D	Continued from page 1 Findings include: R2's Fall Risk Evaluation dated 6/12/25, identified R2 had 1-2 falls in the past 3 months, had intermittent confusion, was ambulatory and continent. R2 had balance problem while standing and walking and required the use of assistive devices. R2 currently takes 3-4 high risk medications. R2 was at risk for falls, with a goal to be free of falls. Interventions: assist R2 with ambulation and transfers utilizing therapy recommendations, determine ability to transfer, and if fall occurs alert provider. R2's quarterly minimum data set (MDS) dated 9/10/25, identified R2's cognition was intact, and had diagnoses of Lewy body dementia (a progressive condition characterized by dementia, parkinsonism, and fluctuations in attention and alertness, along with other symptoms like hallucinations and problems with movement), non-Alzheimer's dementia, anxiety and diabetes. R2 required extensive assist of 1 person for transfers, toileting and toileting hygiene and was frequently incontinent of bladder and occasionally incontinent of bowel. R2 had one fall with no injury and 1 fall with injury. R2's care plan revised 4/25/25, identified a focus that R2 was at risk for falls related to gait, balance and cognition problems. History of falls with major injury, fracture of left hip requiring surgical interventions. Interventions revised on 4/10/25, directed staff to use a stationary nonreclining chair, be sure call light was in reach, Dycem placed on chair surface, use of a Reacher to help with prevention of falls, low pile mat under stationary chair and sign placed in room to remind to use call light to ask for assist. An additional focus revised 3/28/25, identified R2 was incontinent of bladder. Intervention dated 8/23/24, directed staff to monitor/document/report any possible causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects, clean peri area with each incontinent episode and use medium pull up brief, change daily and prn. Furthermore, an additional focus was revised 6/5/25, with activities of daily living (ADL) performance deficit related to disease process. Intervention dated 5/13/25, directed staff that R2 was assist of 1 with front wheeled walker in room for adl's and 8/15/25, identified R2 was 1 assist to the toilet.	F0689		

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F0689 SS = D	Continued from page 2 R2's Fall incident report dated 9/5/25, identified at 2:30 p.m., another resident notified staff that R2 was on the floor. R2 was found face down on the floor next to his bed. R2's clothing was wet, and water was all over the floor. R2 sustained a skin tear to his right knee and knuckles on the right hand were red. R2 stated that he spilled a cup of water on the floor and was reaching forward out of his wheelchair to pick it up when he fell. Immediate action taken: R2 was placed back in his wheelchair per his request and silent alarm engaged. Reinforced the need to use call light. R2's Post Fall evaluation note dated 9/5/25 at 3:30 p.m., identified contributing factors of R2's fall was water was spilled on the floor and was incontinent at the time of the fall. R2's Fall progress note dated 9/5/25 at 4:00 p.m., identified root cause of fall was R2 spilled a cup of water on the floor and was reaching forward out of his wheelchair to pick it up. Intervention was a silent alarm was engaged, and writer reinforced the importance of using his call light when he needed assistance. R2's Fall interdisciplinary team (IDT) note dated 9/5/25 at 4:12 p.m., identified a root cause analysis that R2 dropped his water cup on the floor and reached forward in his wheelchair thinking he could pick it up off the floor. Intervention was R2's grippy socks were on and did not engage his call light. Follow up: signs were up in room to call for assistance and was wearing his call light. Encourage R2 to be out of his room and out in public spaces around others. Review of R2's record identified R2 was incontinent at the time of the fall on 9/5/25, needed assist with toileting, did not identify the last time R2 was toileted, no toileting care plan in place and toileting was not addressed. Furthermore, interventions the facility identified was a silent alarm, encourage to be out of his room and out in public spaces that were not updated to R2's care plan. R2's Fall Risk Evaluation dated 9/10/25, identified R2 had 1-2 falls in the past 3 months, had intermittent confusion, was chairbound and incontinent. R2 had gait/balance problem and required the use of assistive devices. R2 currently took 3-4 high risk medications within the last 7 days. R2 was at risk for falls, with a goal to be free of falls. Interventions: assist R2 with ambulation and transfers utilizing therapy recommendations and if resident was a fall risk initiate fall risk precaution. Clinical suggestion to	F0689		

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F0689 SS = D	Continued from page 3 utilize a toileting program was left blank. R2's fall care plan was revised on 9/16/25 to include anti-tip bars on wheelchair however there was no corresponding assessment that identified why this intervention was implemented. R2's Fall incident report dated 9/23/25 at 6:20 p.m., identified R2 was found sitting on floor in the bathroom leaning backward in front of the toilet. R2 stated, "I was trying to do it by myself." Call light was not engaged. R2 had cut his right thumb and index finger. R2 assisted by using Hoyer lift into his bed. Resident offered complaints of back pain 6 out of 10, PRN (as needed) tramadol (pain med) received. Right thumb and index finger cleaned, steri strip applied, cover with gauze, and rolled gauze. Vital signs within normal limits. Resident Description: Self-transfer. R2 stated he tried to go to the bathroom by himself. Immediate action taken was R2 was assisted into his bed, reeducated on call light use and grippy socks were in place. R2's Fall progress note dated 9/23/25, identified the aforementioned information in addition to, an aide called for assistance in R2's room. Upon arrival R2 was found sitting on floor in the bathroom leaning backward in front of the toilet. Root cause was self-transfer. R2's Post Fall evaluation note dated 9/24/25, identified the fall on 9/23/25 with the aforementioned information. The note also included the contributing factors of this fall were R2 was incontinent at the time of the fall and diagnoses of Lewy bodies, dementia and Parkinson's does not allow R2 to make safe decisions. Root cause of fall was self-transfer. Intervention: R2 was reeducated on call light use and assisted into bed using a Hoyer lift. R2's Fall IDT note dated 9/24/25, identified R2 fell in his bathroom, Root cause analysis was R2 stated, " I wanted to do it myself," and unable to make safe decisions due to his dementia, parkinsonism and Lewy Bodies. Interventions: physical therapy occupational therapy (PT/OT) will work with him to build strength and safe transfers, and we will have the physician review his meds to see if anything needs to be removed or added. R2's progress note dated 9/25/25 at 9:48 p.m., identified R2 continued to demonstrate poor safety awareness, in addition to current fall precautions a cushioned floor mat was placed beside the bed on R2's exit side. The bed is on the lower position and locked,	F0689		

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F0689 SS = D	Continued from page 4 call light within reach. R2 denied having pain or discomfort this evening. Review of R2's record identified although the fall record identified causal factors of self-transfer and R2 was incontinent at the time of the fall on 9/23/25, there was no indication a comprehensive assessment to determine individualized interventions was completed to negate R2's risk of falls related to self-transfers due to needing to use the bathroom. In addition, the care plan was not updated to reflect a low bed or floor mat. R2's Fall progress note dated 9/28/25, identified another resident alerted staff that R2 was on the floor in his room on his knees. R2 was trying to get back in his recliner and was visibly upset about the situation. Root cause was R2 wanted to sit in his recliner, intervention was to remind to use the call light, so he does not get hurt. No injury noted with fall. Intervention was frequent checks completed on R2 throughout the evening. R2's Fall incident report for 9/28/25 was not found in R2's medical record. R2's Fall IDT note dated 9/29/25, identified R2 had a fall in his room on 9/28/25 at 6:15 p.m. Root cause analysis identified potential diagnoses that could have contributed to fall are recent fractured left femur, dementia, parkinsonism, Lewy body dementia, low back pain due to spinal stenosis/lumbar, chronic pain, orthostatic hypotension, history of falling, weakness, and major depressive disorder. Care plan was reviewed with current fall interventions in place, most recent was 6/10/25, anti-tip bars on wheelchair. Interventions pending lab results including urinalysis to guide any additional interventions. Potential interventions include bilateral lower extremity wraps to support blood pressure, obtain ortho blood pressures, place non-slip strips next to bed and in front of toilet, IDT review will convene following test results to determine specific intervention. In review of R2's record there is no indication an intervention was developed and implemented that mitigated the risk of falls based on the identified root cause of R2 independently transferring to his recliner. Furthermore, there was no indication the care plan was updated to include interventions of frequent checks, non-slip strips next to the bed and in front of the toilet. During an observation and interview on 10/2/25 at 9:10 a.m., R2 was seated in his recliner with his front	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245376	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = D	Continued from page 5 wheeled walker within reach. R2 stated he needed help getting to the bathroom so he would not fall. R2 did not always make it to the bathroom in time and had accidents because staff did not always offer to help him to the bathroom. Staff had put a sign in his room to remind him to call for help but did not always remember to look at the sign to call for help. During an interview on 10/2/25 at 1:43 p.m., nursing assistant (NA)-A stated R2 was incontinent of bladder most days. NA-A reviewed R2's Kardex and stated he did not have a toileting care plan, but he should because he needs assist of 1 with toileting and has a history of falling. R2 had diagnosis of Lewy bodies so he did get more confused in the evenings, sometimes had delusions, and did not always remember to use his call light to ask for help with toileting which could lead to him falling. During an interview on 10/2/25, at 2:14 p.m., nurse manager (NM)-A stated two of R2's last three falls identified he was incontinent at the time of the fall and toileting was not addressed and should have been. NM-A stated R2 did not currently have a toileting plan in place but should due to his incontinence and the need for assist with toileting and transfers. NM-A stated each fall should be thoroughly investigated to determine a root cause to ensure the appropriate fall prevention plan is updated to the care plan to direct staff to prevent future falls. NM-A stated R2's last fall was not thoroughly investigated, there was no incident report filled out and there was no post fall incident completed to determine a root cause analysis and there was no new intervention for fall prevention put in place. Facility policy, "Fall Prevention and Management," reviewed 6/5/23, POLICY: The care center will assess each resident for risk of falls and identify interventions to assist in preventing falls and/or injuries. PURPOSE: To provide guidance to care center staff on assessing, identifying, and managing care for those residents at risk for falls. PROCEDURE: The care center will assess each resident's risk for falls at move in, quarterly and with any significant change in condition and will identify interventions to help prevent falls and/or to prevent injuries from falls… D. Post Fall Assessment: If a fall occurs while the individual is residing in the care center (or off premises on a care center specific activity) staff will perform the incident fall tracking assessment. a. Nursing staff will complete a fall scene investigation, assess the resident, and call for any additional assistance or 911 as necessary. b. An immediate	F0689		

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F0689 SS = D	Continued from page 6 intervention will be put into place, according to the immediate determination of the potential root cause of the fall, to prevent further falls until the root cause analysis (RCA) of the incident is completed. c. Nursing staff will document the fall by completing an Incident Report in the electronic medical record. From the immediate assessment of the incident, a determination will be made if the incident involved any maltreatment and/or serious bodily injury. If so, administrative staff will be notified, and a report of the incident will be sent to the State agency… e. The interdisciplinary team (IDT) will evaluate the fall by reviewing the fall incident report to determine a Root Cause Analysis (RCA) of the fall and further interventions may be put into place according to the determined cause of the fall, to help prevent further falls. Any further interventions that are developed will be documented…	F0689		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence,	F0690		

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F0690 SS = D	Continued from page 7 based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to develop an individualized toileting program to maintain or improve bowel/bladder continence for 1 of 3 residents (R2) reviewed for falls. Findings include R2's quarterly minimum data set (MDS) dated 9/10/25, identified R2's cognition was intact, and had diagnoses of Lewy body dementia (a progressive condition characterized by dementia, parkinsonism, and fluctuations in attention and alertness, along with other symptoms like hallucinations and problems with movement), non-Alzheimer's dementia, anxiety and diabetes. R2 required extensive assist of 1 person for transfers, toileting and toileting hygiene and was frequently incontinent of bladder and occasionally incontinent of bowel. In review of R2's record there was no indication a comprehensive bowel and bladder assessment was completed. R2's care plan revised 6/5/25, identified a focus with activities of daily living (ADL) performance deficit related to disease process. Goal revised 8/5/25, identified to improve current level of function through the review date, will be back to baseline and assist with adl's. Intervention dated 5/13/25, assist of 1 with front wheeled walker in room for adl's and 8/15/25, identified R2 was 1 assist to the toilet. An additional focus revised 3/28/25, identified R2 was incontinent of bladder. Goal revised 8/8/25, identified R2 will remain free from skin breakdown due to incontinence and brief use through the review date. Intervention dated 8/23/24, identified to monitor/document/report any possible causes of incontinence: bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects, clean peri area with each incontinent episode and use medium pull up brief, change daily and prn. R2's care plan did not include and individualized toileting schedule/program.	F0690		

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F0690 SS = D	Continued from page 8 During an observation and interview on 10/2/25 at 9:10 a.m., R2 was seated in his recliner and had his front wheeled walker within reach. R2 stated he needed help getting to the bathroom, so he doesn't fall. R2 did not always get to the bathroom in time and would have accidents because staff did not always offer to help him to the toilet. R2 stated staff put this a sign on his dresser to remind him to call for help so he doesn't fall, but he did not always remember to look at the sign to ask for help. R2 explained that it's difficult to remember to look for a sign and press the help button when you instinctively assume you can do things on your own. During an interview on 10/2/25 at 1:43 p.m., nursing assistant (NA)-A stated R2 was incontinent of bladder most days. NA-A reviewed R2's kardex and stated he did not have a toileting care plan, but he should because he needs assist of 1 with toileting and has a history of falling. R2 did get more confused in the evenings, sometimes had delusions, and did not always remember to use his call light to ask for help with toileting. During an interview on 10/2/25, at 2:14 p.m., nurse manager (NM)-A stated R2 did not currently have a toileting plan in place but should have one due to his incontinence and the need for assist with toileting and transfers. NM-A was unable to articulate a treatment and service plan to improve or maintain bowel and bladder. NM-A stated the facility "did not really" have a process in place for a personalized toileting plan and indicated they need to develop one. Facility policy titled, "Urinary Incontinence Program," reviewed 4/16/15, identified POLICY: St. Francis Health Services of Morris, Inc. (SFHS) provides care to those residents who are incontinent that will restore normal bladder and bowel function to the greatest extent possible, or at least prevent related incontinence complications. PURPOSE: Each resident who is incontinent will be identified, assessed, and provided appropriate care and services to achieve or maintain their greatest level of continence. Each resident will receive the appropriate care and services to prevent incontinence related complications to the extent possible… PROCEDURE: A. Each resident will be evaluated upon admission. The evaluation will include completion of a baseline review of the resident's elimination status. A comprehensive assessment, which will include a three (3) day bowel and bladder pattern assessment, will be completed within the initial assessment period. a. Based on the initial urinary incontinence or bowel incontinence history reported by the resident and/or family member(s), the new resident will be assisted in	F0690		

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F0690 SS = D	Continued from page 9 using incontinence products provided by the care center. Measurements of the resident, pattern of reported incontinence, incontinence product protocols for product use, and resident choice will be considered in the choice of incontinence product(s). b. The 3-day bowel and bladder pattern assessment will be completed and documented in hourly increments. A component of the three (3) day bowel and bladder pattern assessment may include bladder ultrasound equipment use. c. The comprehensive bowel and bladder assessment will include a report of prior incontinence history, a physical examination, documentation of genitourinary tract anomalies, results of the three (3) day bowel and bladder pattern, a review of diagnoses and medications that may impact urinary or bowel status, food and fluid intake patterns, environmental concerns as well as the consideration of adaptive devices, review of potential or existing complications of incontinence, and the resident's level of need for assistance due to physical or cognitive impairments. This assessment will be used to determine an individualized bowel and bladder program for each resident. "Bowel and Bladder Policy," revised 8/2023, indicated each resident receives the necessary care and service to attain or maintain the highest practicable level of bowel and bladder continence…2. The comprehensive assessment results are used to develop a care plan addressing the individual needs of each resident. Care plan interventions are determined with consideration of: a. the ability of the resident to make decisions and call for assistance to use the toilet. B. The presence of permanent physical impairment or disease which could prevent incontinence. C. Resident's desire to participate in bowel and bladder programing. D. current standards of practice in accordance with state and federal law. 3. Review of the comprehensive assessment and care plan will occur on at least a quarterly basis and more frequently if there is a change in residents' condition…	F0690		

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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 10/1/25 and 10/2/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		

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

Minnesota State Department of Health

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20000	Continued from page 1 The following complaints were reviewed. H53764463C (2615914) with a licensing order issued at 0830. 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		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the	20830		

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20830	Continued from page 2 resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess each fall to identify and analyze causal factors for potential root cause in order to determine individualized interventions to prevent or decrease the risk for future falls for 1 of 3 residents (R2) reviewed for falls. Findings include: R2's Fall Risk Evaluation dated 6/12/25, identified R2 had 1-2 falls in the past 3 months, had intermittent confusion, was ambulatory and continent. R2 had balance problem while standing and walking and required the use of assistive devices. R2 currently takes 3-4 high risk medications. R2 was at risk for falls, with a goal to be free of falls. Interventions: assist R2 with ambulation and transfers utilizing therapy recommendations, determine ability to transfer, and if fall occurs alert provider. R2's quarterly minimum data set (MDS) dated 9/10/25, identified R2's cognition was intact, and had diagnoses of Lewy body dementia (a progressive condition characterized by dementia, parkinsonism, and fluctuations in attention and alertness, along with other symptoms like hallucinations and problems with movement), non-Alzheimer's dementia, anxiety and diabetes. R2 required extensive assist of 1 person for transfers, toileting and toileting hygiene and was frequently incontinent of bladder and occasionally incontinent of bowel. R2 had one fall with no injury and 1 fall with injury. R2's care plan revised 4/25/25, identified a focus that R2 was at risk for falls related to gait, balance and cognition problems. History of falls with major injury, fracture of left hip requiring surgical interventions. Interventions revised on 4/10/25, directed staff to use a stationary nonreclining chair, be sure call light was in reach, Dycem placed on chair surface, use of a Reacher to help with prevention of falls, low pile mat under stationary chair and sign placed in room to remind to use call light to ask for assist. An additional focus revised 3/28/25, identified R2 was incontinent of bladder. Intervention dated 8/23/24, directed staff to monitor/document/report any possible causes of incontinence: bladder infection,	20830		

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20830	Continued from page 3 constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, stroke, medication side effects, clean peri area with each incontinent episode and use medium pull up brief, change daily and prn. Furthermore, an additional focus was revised 6/5/25, with activities of daily living (ADL) performance deficit related to disease process. Intervention dated 5/13/25, directed staff that R2 was assist of 1 with front wheeled walker in room for adl's and 8/15/25, identified R2 was 1 assist to the toilet. R2's Fall incident report dated 9/5/25, identified at 2:30 p.m., another resident notified staff that R2 was on the floor. R2 was found face down on the floor next to his bed. R2's clothing was wet, and water was all over the floor. R2 sustained a skin tear to his right knee and knuckles on the right hand were red. R2 stated that he spilled a cup of water on the floor and was reaching forward out of his wheelchair to pick it up when he fell. Immediate action taken: R2 was placed back in his wheelchair per his request and silent alarm engaged. Reinforced the need to use call light. R2's Post Fall evaluation note dated 9/5/25 at 3:30 p.m., identified contributing factors of R2's fall was water was spilled on the floor and was incontinent at the time of the fall. R2's Fall progress note dated 9/5/25 at 4:00 p.m., identified root cause of fall was R2 spilled a cup of water on the floor and was reaching forward out of his wheelchair to pick it up. Intervention was a silent alarm was engaged, and writer reinforced the importance of using his call light when he needed assistance. R2's Fall interdisciplinary team (IDT) note dated 9/5/25 at 4:12 p.m., identified a root cause analysis that R2 dropped his water cup on the floor and reached forward in his wheelchair thinking he could pick it up off the floor. Intervention was R2's grippy socks were on and did not engage his call light. Follow up: signs were up in room to call for assistance and was wearing his call light. Encourage R2 to be out of his room and out in public spaces around others. Review of R2's record identified R2 was incontinent at the time of the fall on 9/5/25, needed assist with toileting, did not identify the last time R2 was toileted, no toileting care plan in place and toileting was not addressed. Furthermore, interventions the facility identified was a silent alarm, encourage to be out of his room and out in public spaces that were not	20830		

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20830	Continued from page 4 updated to R2's care plan. R2's Fall Risk Evaluation dated 9/10/25, identified R2 had 1-2 falls in the past 3 months, had intermittent confusion, was chairbound and incontinent. R2 had gait/balance problem and required the use of assistive devices. R2 currently took 3-4 high risk medications within the last 7 days. R2 was at risk for falls, with a goal to be free of falls. Interventions: assist R2 with ambulation and transfers utilizing therapy recommendations and if resident was a fall risk initiate fall risk precaution. Clinical suggestion to utilize a toileting program was left blank. R2's fall care plan was revised on 9/16/25 to include anti-tip bars on wheelchair however there was no corresponding assessment that identified why this intervention was implemented. R2's Fall incident report dated 9/23/25 at 6:20 p.m., identified R2 was found sitting on floor in the bathroom leaning backward in front of the toilet. R2 stated, "I was trying to do it by myself." Call light was not engaged. R2 had cut his right thumb and index finger. R2 assisted by using Hoyer lift into his bed. Resident offered complaints of back pain 6 out of 10, PRN (as needed) tramadol (pain med) received. Right thumb and index finger cleaned, steri strip applied, cover with gauze, and rolled gauze. Vital signs within normal limits. Resident Description: Self-transfer. R2 stated he tried to go to the bathroom by himself. Immediate action taken was R2 was assisted into his bed, reeducated on call light use and grippy socks were in place. R2's Fall progress note dated 9/23/25, identified the aforementioned information in addition to, an aide called for assistance in R2's room. Upon arrival R2 was found sitting on floor in the bathroom leaning backward in front of the toilet. Root cause was self-transfer. R2's Post Fall evaluation note dated 9/24/25, identified the fall on 9/23/25 with the aforementioned information. The note also included the contributing factors of this fall were R2 was incontinent at the time of the fall and diagnoses of Lewy bodies, dementia and Parkinson's does not allow R2 to make safe decisions. Root cause of fall was self-transfer. Intervention: R2 was reeducated on call light use and assisted into bed using a Hoyer lift. R2's Fall IDT note dated 9/24/25, identified R2 fell in his bathroom, Root cause analysis was R2 stated, " I wanted to do it myself," and unable to make safe	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/26/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zumbrota Care Center	**433 MILL STREET , ZUMBROTA, Minnesota, 55992**

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20830	Continued from page 5 decisions due to his dementia, parkinsonism and Lewy Bodies. Interventions: physical therapy occupational therapy (PT/OT) will work with him to build strength and safe transfers, and we will have the physician review his meds to see if anything needs to be removed or added. R2's progress note dated 9/25/25 at 9:48 p.m., identified R2 continued to demonstrate poor safety awareness, in addition to current fall precautions a cushioned floor mat was placed beside the bed on R2's exit side. The bed is on the lower position and locked, call light within reach. R2 denied having pain or discomfort this evening. Review of R2's record identified although the fall record identified causal factors of self-transfer and R2 was incontinent at the time of the fall on 9/23/25, there was no indication a comprehensive assessment to determine individualized interventions was completed to negate R2's risk of falls related to self-transfers due to needing to use the bathroom. In addition, the care plan was not updated to reflect a low bed or floor mat. R2's Fall progress note dated 9/28/25, identified another resident alerted staff that R2 was on the floor in his room on his knees. R2 was trying to get back in his recliner and was visibly upset about the situation. Root cause was R2 wanted to sit in his recliner, intervention was to remind to use the call light, so he does not get hurt. No injury noted with fall. Intervention was frequent checks completed on R2 throughout the evening. R2's Fall incident report for 9/28/25 was not found in R2's medical record. R2's Fall IDT note dated 9/29/25, identified R2 had a fall in his room on 9/28/25 at 6:15 p.m. Root cause analysis identified potential diagnoses that could have contributed to fall are recent fractured left femur, dementia, parkinsonism, Lewy body dementia, low back pain due to spinal stenosis/lumbar, chronic pain, orthostatic hypotension, history of falling, weakness, and major depressive disorder. Care plan was reviewed with current fall interventions in place, most recent was 6/10/25, anti-tip bars on wheelchair. Interventions pending lab results including urinalysis to guide any additional interventions. Potential interventions include bilateral lower extremity wraps to support blood pressure, obtain ortho blood pressures, place non-slip strips next to bed and in front of toilet, IDT review will convene following test results to determine specific intervention.	20830		

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20830	Continued from page 6 In review of R2's record there is no indication an intervention was developed and implemented that mitigated the risk of falls based on the identified root cause of R2 independently transferring to his recliner. Furthermore, there was no indication the care plan was updated to include interventions of frequent checks, non-slip strips next to the bed and in front of the toilet. During an observation and interview on 10/2/25 at 9:10 a.m., R2 was seated in his recliner with his front wheeled walker within reach. R2 stated he needed help getting to the bathroom so he would not fall. R2 did not always make it to the bathroom in time and had accidents because staff did not always offer to help him to the bathroom. Staff had put a sign in his room to remind him to call for help but did not always remember to look at the sign to call for help. During an interview on 10/2/25 at 1:43 p.m., nursing assistant (NA)-A stated R2 was incontinent of bladder most days. NA-A reviewed R2's Kardex and stated he did not have a toileting care plan, but he should because he needs assist of 1 with toileting and has a history of falling. R2 had diagnosis of Lewy bodies so he did get more confused in the evenings, sometimes had delusions, and did not always remember to use his call light to ask for help with toileting which could lead to him falling. During an interview on 10/2/25, at 2:14 p.m., nurse manager (NM)-A stated two of R2's last three falls identified he was incontinent at the time of the fall and toileting was not addressed and should have been. NM-A stated R2 did not currently have a toileting plan in place but should due to his incontinence and the need for assist with toileting and transfers. NM-A stated each fall should be thoroughly investigated to determine a root cause to ensure the appropriate fall prevention plan is updated to the care plan to direct staff to prevent future falls. NM-A stated R2's last fall was not thoroughly investigated, there was no incident report filled out and there was no post fall incident completed to determine a root cause analysis and there was no new intervention for fall prevention put in place. Facility policy, "Fall Prevention and Management," reviewed 6/5/23, POLICY: The care center will assess each resident for risk of falls and identify interventions to assist in preventing falls and/or injuries. PURPOSE: To provide guidance to care center staff on assessing, identifying, and managing care for	20830		

Minnesota State Department of Health

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20830	Continued from page 7 those residents at risk for falls. PROCEDURE: The care center will assess each resident's risk for falls at move in, quarterly and with any significant change in condition and will identify interventions to help prevent falls and/or to prevent injuries from falls… D. Post Fall Assessment: If a fall occurs while the individual is residing in the care center (or off premises on a care center specific activity) staff will perform the incident fall tracking assessment. a. Nursing staff will complete a fall scene investigation, assess the resident, and call for any additional assistance or 911 as necessary. b. An immediate intervention will be put into place, according to the immediate determination of the potential root cause of the fall, to prevent further falls until the root cause analysis (RCA) of the incident is completed. c. Nursing staff will document the fall by completing an Incident Report in the electronic medical record. From the immediate assessment of the incident, a determination will be made if the incident involved any maltreatment and/or serious bodily injury. If so, administrative staff will be notified, and a report of the incident will be sent to the State agency… e. The interdisciplinary team (IDT) will evaluate the fall by reviewing the fall incident report to determine a Root Cause Analysis (RCA) of the fall and further interventions may be put into place according to the determined cause of the fall, to help prevent further falls. Any further interventions that are developed will be documented… SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents, and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		