Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 12, 2026

Administrator
FAIRWAY VIEW NEIGHBORHOODS
201 MARK DRIVE
ORTONVILLE, MN 56278

Re: Event ID: 1DF025-H1

Dear Administrator:

The above facility survey was completed on December 24, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Freeman Building | HRD-OLF 3B
625 Robert St. N.
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

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January 12, 2026

Administrator
FAIRWAY VIEW NEIGHBORHOODS
201 MARK DRIVE
ORTONVILLE, MN 56278

RE: CCN: 245451
Cycle Start Date: December 24, 2025

Dear Administrator:

On December 24, 2025, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J).

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On December 18, 2025, the situation of immediate jeopardy to potential health and safety cited at F0600: Free from Abuse and Neglect, was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

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

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial

extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 24, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, FAIRWAY VIEW NEIGHBORHOODS is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective December 24, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Freeman Building | HRD-OLF 3B
625 Robert St. N.
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245451	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY VIEW NEIGHBORHOODS	201 MARK DRIVE , ORTONVILLE, Minnesota, 56278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 5/12/25-5/14/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		
F0000	INITIAL COMMENTS On 5/12/25 to 5/14/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. 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 with NO deficiencies cited : H54513210C (MN00109583) H54513209C (MN00109792) H54513211C (MN00110581) 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	F0000		

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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F0000	Continued from page 1 revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure an insulin SoloStar Insulin pen was appropriately primed prior to insulin administration for 1 of 2 residents (R30) who received 25 units of Lantus insulin daily. Findings include: During an observation and interview on 5/12/25 at 5:50 p.m., licensed practical nurse (LPN)-A prepared to administer R30's ordered dose of Lantus insulin. The current physician orders for Lantus Solostar insulin identified he was to receive 25 units subcutaneously (subcutaneous injections are used to administer medications between skin and muscle) once per day, with a special note which identified the insulin was to be administered between 4:00 p.m. and 6:00 p.m. daily per resident request. LPN-A checked the pen against the Medication Administration Record (MAR), performed hand hygiene, removed the pen cap, wiped the end of the pen with an alcohol pad, attached the needle, dialed the pen to one unit and depressed the plunger, no insulin was observed exiting the needle. LPN-A then dialed the pen to 25 units, retrieved a new alcohol pad and proceeded to R30's room to administer the dose of insulin. LPN-A was interrupted, and she and the surveyor exited the room, where LPN-A was asked about her procedure for priming (removes the air from the needle and cartridge that may collect during normal use. This ensures ensures receiving the full dose) the insulin pen. She replied her normal procedure was to prime the pen with one or two units, and then dial to the ordered dose of insulin. LPN-A stated she was not aware of what the manufacturer's directions instructed for priming the pen by dialing to two units after attaching the needle. LPN-A wasted the dose of insulin, dialed the pen to two units, demonstrating the insulin	F0760	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. R30 did not receive Lantus insulin prior to the pen being primed as the LPN administering the medication was provided with education prior to the error occurring. All residents who receive insulin via insulin pens are at risk due of this deficient practice. Individual nurse was re-educated by DON on 5/12/25. To ensure systemic changes are sustained, all nurses will complete Sanford Learn ED-4916 Insulin Preparation by 5/31/25. 2025 Annual Training does include training and competency testing for insulin preparation. To ensure compliance is maintained, the DON or designee will audit insulin pen administration, including priming the pen, weekly x 4 and monthly x 3 beginning the week of 5/26. Audit results will be brought to the QAPI committee for further recommendations.	05/31/2025

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F0760 SS = D	Continued from page 2 coming through the needle, performed hand hygiene, applied gloves, and proceeded to administer R30's insulin in his left lower abdomen. LPN-A stated she had always primed insulin pens in that manner and was not aware she needed to prime with two units to remove air from the needle. During an interview on 5/13/25 at 8:30 a.m., the director of nursing (DON) stated her expectation for licensed nursing staff administering insulin was to follow the manufacturer's instructions and the facility policy for priming pens with two units prior to administration of the ordered insulin dose. Review of the manufacture's instruction sheet: How to use your Lantus SoloStar pen: - a short version of the instruction leaflet included in the Lantus SoloStar pen box. The pamphlet detailed the importance of following the listed steps to help ensure an accurate dose of insulin was received. 1.) Remove the pen cap with clean hands. Check the reservoir to ensure it is clear and colorless and has no particles. 2.) Wipe the pen tip (rubber seal) with an alcohol swab. 3.) Remove the protective seal from the new needle, line the needle up straight with the pen and screw the needle onto the pen. 4.) After attaching the needle, remove the outer needle cap and save to remove the needle after the injection. 5.) Remove the inner needle cap and discard. 6.) Dial the pen to 2, hold the pen upright, tap the reservoir to bring any bubbles to the top, depress the plunger and ensure insulin exits the needle. The dial will automatically return to zero. 7.) Check to ensure the dial returned to zero, and then dial to the ordered dose of insulin.	F0760		

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F0760 SS = D	Continued from page 3 8.) Clean the injection site with an alcohol pad, Hold the pen straight, insert the needle into the skin, depress the plunger and wait 10 seconds before releasing the plunger and removing. 9.) Replace the outer needle cap over the needle and remove the needle from the pen and dispose in a sharps container. Review of the Revised September 2014 Med-Pass, Inc policy Insulin Administration identified nursing staff were to have access to manufacturer's instructions for all types of insulin administration devices prior to use. The policy identified steps for use of an insulin pen: Verify the physician orders for the type and dose of insulin to be administered; Prime the pen with 2 units of insulin; dial the pen to the ordered dose; administer the insulin in the identified body location; and wash hands following administration of the medication.	F0760		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F0812	The meat slicer and fire suppression pipes above the deep fat fryer and stove top grill were cleaned immediately upon finding on 5/12/25. The light fixtures were also cleaned immediately upon finding on 5/14/25. The hood and filter cleaning policy was reviewed and updated on 5/22/25 to specifically address the cleaning of suppression system pipes and light covers in the procedure. The weekly cleaning schedule was revised on 5/22/25 to specifically address the suppression pipes and light covers under the hood cleaning assignment. Midwest Fire & Safety was contacted regarding the kitchen suppression system and inspected the unit on 5/15/25. Midwest Fire & Safety recommended replacement of the suppression pipes. Maintenance Director will replace by 5/31/25. The meat slicer policy was reviewed and updated on 5/22/25 with a more specific procedure of cleaning and sanitizing the machine. The updated policies was reviewed and approved at the	05/31/2025

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F0812 SS = F	Continued from page 4 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure fire suppression pipes located directly above the deep fat fryer, and stove top grill surface were free from accumulation of dirt and grease. This buildup had the potential to contaminate food being prepared and served. In addition, the facility failed to ensure 1 of 1 meat slicer was appropriately cleaned and sanitized following use. These deficient practices had the potential to affect all 51 residents who received food prepared in the facility kitchen. Findings include: During an observation and interview on 5/12/25 at 12:33 p.m., with the certified dietary manager (CDM) identified the vent hood located above the stove top grill and deep fat fryer, contained metal pipes identified as the fire suppression system, which were coated with a black fuzzy substance the CDM identified as dirt and grease buildup. Both the pipes and light fixtures in the hood had multiple areas identified as rust. The CDM stated she had only been in her position for two weeks and had not noticed the buildup on the ends of the fire suppression pipes. CDM indicated she would have the area cleaned immediately due to the potential for contamination of food being prepared. Observation of a meat slicer identified as last used on 5/11/25, to slice ham was on a counter and covered with plastic. When the plastic was removed, food particles were observed on the shield behind the blade, on the platform, and there was buildup of food particles on the sides and grooved surface of the unit. The CDM confirmed the meat slicer had not been cleaned and sanitized appropriately following use and would need to be cleaned prior to being used again. During an interview on 5/12/25 at 12:45 p.m. , the CDM identified her expectation was for cleaning schedules to be followed and identified the need for improvement and monitoring of cleaning and sanitation of food preparation equipment located in the facility kitchen. CDM stated the vented hood was due for an annual cleaning however, confirmed she had not noticed the buildup on the pipes located above the food preparation surfaces.	F0812	Continued from page 4 5/27/25 QAPI meeting. The Director of Food and Nutrition Services held a cook's in-service on 5/27/25 to include the following topics: reviewing the updated hood and meat slicer policies, reviewing the updated cleaning schedule and a demonstration by presenter on how to properly clean the hood, fire suppression system and removal and cleaning of the light covers along with a demonstration on how to clean and sanitize the meat slicer. The hood system and meat slicer will be cleaned according to policy and the completed tasks will be recorded on the cleaning schedule. The cleaning and documenting of the hood and meat slicer will be audited for compliance by the Director of Food and Nutrition Services weekly x 4 weeks, bi-monthly x 1 month, and monthly thereafter until the compliance rate is 100% for 3 consecutive months. The corrective action plan will be added to the dietary QAPI plan and audit results/further action will be reviewed and reported on at QAPI meetings until goal is met.	

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F0812 SS = F	Continued from page 5 A policy for scheduled kitchen maintenance/cleaning was requested, but not provided by the end of the survey period. Review of the 2008 policy for cleaning slicers identified the slicer was to be cleaned and sanitized after each use. All parts of the slicer were to be disassembled and washed in the pots and pans sink or dish machine. All parts were to be sanitized in a chemical sanitizer, or in the dishwasher. The remaining parts of the slicer that could not be placed in the dishwasher were to be washed with hot water and soap, rinsed and allowed to dry. Special attention was to be paid to any moveable parts, especially the blade. The parts were to be sanitized and allowed to dry, the slicer was to be reassembled and covered. The counter where the slicer was located was also to be washed and sanitized with each use of the slicer.	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F0880	Staff member involved was immediately educated on the appropriate procedures of disinfection of a glucometer between uses. All other residents who have their blood glucose checked using a glucometer have the risk to be affected by this deficient practice. To ensure systemic changes are sustained, the policy titled “NOVA Statstrip Meter Procedure” was updated to include verbiage on cleaning the meter including, “Per Infection Prevention and Control Administrative SOP Shared Medical Equipment, the meters exterior will be cleaned between each patient. Commercial surface decontamination approved by OAHS may be used (i.e.Sani-Cloth AF3 - Grey Lid). Refer to User's Manual for specific instructions for each meter. Allow meter to remain wet for appropriate contact time depending on germicidal wipe in use.” The updated policy was reviewed and approved at the 5/27/25 QAPI meeting. A video on the proper use of Sani-Cloth AF3 was sent to all nursing staff who use glucometer of 5/16/25. Infection Preventionist will develop a tool for staff to include the type of sani-cloth, what the sani-cloth is used for, and proper wet time to disinfect. All staff will be educated on the proper process for using Sani-Cloths AF3 and all sani-cloths by 5/31/25.	05/31/2025

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F0880 SS = D	Continued from page 6 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the common use blood glucometer machines were disinfected according to current manufacturer's guidelines between resident use	F0880	Continued from page 6 All staff using glucometers will complete a competency quiz on the proper use of germicidal wipes when disinfecting glucometers by 5/31/25. During QAPI meeting on 5/27/25, the type of wipe used on glucometers was reviewed. During the meeting, the IDT team made the decision to switch to a different germicidal wipe that has a shorter required time that it need to be visibly wet compared to the 3 minutes the Sani-Cloth AF3 requires. This transition will take place after the Sani-Cloth AF3s are used up. To ensure compliance is maintained, starting the week of 5/26/25, DON or Nurse Lead will audit 2 glucometer disinfection opportunities per household per week on the proper disinfection of glucometers weekly for 4 weeks, and monthly for 3 months. This plan of correction will be monitored and brought to our monthly QAPI meeting.	

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F0880 SS = D	Continued from page 7 for 2 of 3 residents (R44 and R1) reviewed who received blood glucose testing in the facility. Findings include: Observation on 5/12/25 at 5:27 p.m. with trained medication aide (TMA)-A as she prepared to check a blood glucose for R44. TMA-A took the glucometer from the charging station located at the nursing station, collected her necessary supplies, and proceeded to R 44's room where she donned personal protective equipment (PPE) of gown and gloves. TMA-A obtained a clean towel which she placed on the bedside table and placed the glucometer and supplies on the towel. She then washed her hands, put on new gloves, scanned the bottle of test strips and placed a strip into the glucometer. TMA-A wiped R44's finger with an alcohol pad, allowed to dry and utilized a lancet (A lancet is a small, sharp surgical instrument used to make small incisions, typically for drawing blood samples. It is commonly used in diabetes management) to obtain a blood sample which she collected with the test strip. TMA-A placed a cotton ball on R44's finger and after obtaining a reading disposed of the used items in the sharp's container in R44's bathroom. She removed her PPE and performed hand hygiene. TMA-A went out of the room to her cart positioned outside the room and proceeded to wipe off the glucometer, and bottle of strips with alcohol pads. She stated she would need to clean the glucometer and bottle of strips again as she had contaminated them when she was removing her PPE. TMA-A returned to the nursing station, retrieved alcohol pads, and wiped off the glucometer and bottle of strips with the alcohol pads and returned to the docking station. When asked, she confirmed the glucometer was disinfected and ready to use for the next test. During an observation and interview on 5/12/25 at 5:50 p.m., with registered nurse (RN)-A as she retrieved the common use glucometer and identified she was going to check a blood sugar and administer R44's insulin. RN-A obtained her supplies, used hand sanitizer and proceeded to the area outside R44's room where she donned PPE of gown and gloves. RN-A took a gray labeled Sani Cloth, wiped over the surface of the common use glucometer and set aside to dry. RN-A stated the glucometer needed to remain wet for three minutes however, did not leave the meter in contact with the cloth and confirmed the meter was dry within a little more than a minute. RN-A reported she had not ensured	F0880		

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F0880 SS = D	Continued from page 8 the meter remained wet for the three minute time period and had never checked to determine how long it took for the solution to dry after wiping the surface. During an interview on 5/12/25 at 5:55 p.m., TMA-A stated she was not aware that alcohol was not the correct product to use for disinfecting the common use glucometers, and that she was not aware of how the manufacturer and/or policy directed the meter to be cleaned and disinfected following use. RN-A who was also in attendance, confirmed to TMA-A the glucometer was supposed to be disinfected using the gray labeled Sani cloth wipes and reported she had just realized the solution needed to remain wet on the surface for three minutes to disinfect the surface. During an observation and interview on 5/12/25 at 12:03 p.m., TMA-B cleansed hands and applied gloves prior to checking resident blood sugars. TMA-B placed a test strip into the common use glucometer, cleansed R1's middle right finger with an alcohol wipe, used a lancet to prick her finger and dropped the sample of blood onto the test strip. At 12:08 p.m., TMA-B sanitized the common use glucometer with a single use Sani wipe by wiping the front and back briefly and placed the glucometer on her cart. When interviewed, TMA-B stated she believed the glucometer was sanitized after wiping it as she had. TMA-B removed gloves and sanitized her hands. TMA-B entered the results into R1's electronic medical record and moved her cart down the hallway to the hallway located to the right of the dining room. At 12:12 p.m., TMA-B was bringing R9 to a private area to check her blood sugar when surveyor stopped her and asked her to review the manufacturer's guidelines for the Sani wipe she used for sanitizing the glucometer. TMA-B reviewed the instructions and did confirm the instructions identified the glucometer was to remain wet for three minutes to ensure proper sanitization. TMA-B confirmed she had not done that as instructed. TMA-B removed a new Sani wipe, wiped the glucometer down on each side and wrapped the wipe around the glucometer as instructed before she continued on with further blood sugar checks. During a telephone interview on 5/14/25 at 10:08 a.m., infection preventionist (IP) stated the common use glucometers required sanitization between each resident's use. IP identified staff wre expected to use the Sani wipes by wiping three times horizontal and three times vertical and ensure the glucometer remained wet for three minutes. IP stated that may mean staff	F0880		

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F0880 SS = D	Continued from page 9 were to re-wipe the glucometer if needed to ensure it remained wet for three minutes. IP indicated it was the facility's expectation staff would follow the wet time as indicated to prevent the spread of blood-borne pathogens. During an interview on 5/13/25 at 1:15 p.m. the director of nursing (DON) identified her expectation for the common use glucometer was to be cleaned and disinfected after each use according to the policy and manufacturer's instructions. DON identified alcohol wipes were not the appropriate solution for disinfection of the meter and the gray labeled Sani Cloths were available for that purpose. Review of manufacturer's instructions for Sani-Cloth AF3 Germicidal Wipes General Guidelines for Use dated 2019, instructed staff to unfold a clean wipe and thoroughly wet the surface. Allow treated surface to remain wet for three minutes and let air dry. Review of the January 27, 2025, Nova StatStrip Meter Procedure identified according to Infection Prevention (IC) the meter's exterior was to be cleansed between each patient. The decontamination preparation approved was identified as Sani-Cloth AF3-grey lid. The strip port was to be cleansed by lab staff only. Do not immerse meter or hold the meter under running water. Do not spray with a disinfectant solution.	F0880		

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F0000	INITIAL COMMENTS On 12/19/25, and 12/22/25 through 12/24/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed H54511520C (2694007) with a deficiency issued at F600 PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F0000		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation and document review, the facility failed to ensure 1 of 1 resident (R1) was free from neglect when R1 had a fall, intentionally not reported by staff, which delayed necessary medical care	F0600	"Past Noncompliance - no plan of correction required"	

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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F0600 SS = SQC-J	Continued from page 1 for two hours. This resulted in an immediate jeopardy (IJ) for R1 when, as a result of the fall, she was treated at the emergency department (ED) where she was diagnosed with a laceration to her forehead, an abrasion, bruising, concussion and a fracture of the sternum. The IJ began on 12/15/25 at 7 p.m., when nurse aide (NA)-A transferred R1 alone (care plan directs assist of two) and R1 fell off the edge of the bed which resulted in bleeding laceration on her forehead and NA-A intentionally did not report the fall or seek appropriate medical care until two hours later. The administrator, director of nursing (DON), and primary care provider medical doctor (MD) were notified of the IJ on 12/23/25 at 4:30 p.m. The facility implemented corrective action by 12/18/25, prior to the start of the survey, and therefore is issued as past non-compliance. Findings include: R1's significant change Minimum Data Set (MDS) dated 11/8/25, indicated severely impaired cognition, with disorganized and incoherent thinking (rambling, unclear, illogical flow of ideas, or irrelevant conversation) altered level of consciousness, and long and short-term memory loss. She was dependent (required assistance of two or more staff to complete) personal hygiene, bathing/shower, sit to stand, all transfers, and used a manual wheelchair for mobility. Her medical diagnoses included Alzheimer's Disease, dementia, and anxiety. Since admission she had two falls without injury and one with injury (except major). R1’s Face Sheet identified diagnoses history of falling and transient ischemic attack (TIA) (stroke)/cerebral infarction (area of necrotic (death of) tissue in the brain due to disrupted blood supply), and osteoporosis (caused bones to become weak and brittle.) R1's care plan dated 11/5/25, identified R1 had difficulty understanding others due to dementia. Staff were directed to speak clearly, repeat phases as needed, and ask simple yes or no questions. She required 24-hour supervision and care which placed her at a greater risk for abuse and neglect. She had altered ability to care for herself due to cognition, unable to walk, dependent upon staff for all transfers, and may use EZ stand as needed with a medium sling. She	F0600		

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F0600 SS = SQC-J	Continued from page 2 was at risk for falls due history of falls, staff were directed to give verbal reminders not to ambulate, transfer without assistance, bed in lowest position, observe frequently and place in supervised area when out of bed, pressure sensor when in bed to alert staff when trying to get out of bed, and call light within reach always. She had impaired decision making due to dementia and staff were directed to provide cues, supervision, determine if decisions made by her endangered herself or others and intervene if necessary. On 12/18/25, R1's care plan was updated to include stand pivot transfer (SPT) with assist of two if alert, Hoyer lift, and assist of two with medium sling. Physical therapy (PT) evaluation and plan of treatment dated 10/27/25, identified referral was made due to change in cognition and mobility status. Staff reported hard to transfer with assist of one to two with pivot transfers due to resident unable to understand completion of task. Staff reported the use of EZ stand had been difficult due to resident unsure of the task and hard to explain to her. She was identified as high risk for falls due to cognitive status and unable to follow cueing for safety. Clinical impression of evaluation: a cognitive decline was identified, a hard time with constant movement and conversation causing limitations in orientation to task. She was able to complete the SPT from wheelchair to chair with moderate assistance but attempted to sit in the middle of transfer and required maximum assistance to reposition. EZ stand transfer was completed and required assist of two throughout to attend to task, keep safely of extremities, and allow for best maneuver of transfer. PT discussed with staff on this date, will maintain SPT and EZ stand, with discussion on addition of Hoyer as needed in upcoming sessions. R1's order start date 10/27/25 through 12/18/25, listed under activities of daily living (ADL) flow sheet, identified activity as tolerated; SPT assist of two or EZ stand transfer with assist of two per patient cognition and ability to follow cues (this had not been added to R1’s care plan). /R1's order start date 12/18/25, listed under ADLs flow sheet, identified activity as tolerated; stand pivot transfer with assist of two if alert. Hoyer lift due to fracture and medium sling. R1’s fall risk assessment dated 11/30/25, identified intermittent confusion, poor recall judgment, and safety awareness. R1 had balance problems with standing, impaired mobility,	F0600		

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F0600 SS = SQC-J	Continued from page 3 and required the use of wheelchair. Fall risk score was 18 (16-20 had high likelihood of a fall occurring) and indicated high risk for falls. R1's progress notes from 12/15/25, through 12/19/25, identified: -On 12/16/25 12:19 a.m., nurse was called to R1's room at about 9:00 p.m. (12/15/25). She had a hematoma and discoloration on right side of face around eyebrow, large gash about 3 centimeters (cm) long on top left side of head, and partially dry blood running down left side of head. R1 was snoring heavily while nurse wiped blood away using gauze to check the size of the cut, left eye was rolled back, and right pupil was pinpoint. R1 was difficult to wake, a second nurse was called over, DON contacted, and vitals taken. Staff stated she was put to bed about 7:00 p.m., checked at about 9:00 p.m., which was when the gash was found. Sternal rub used at which time she arose and asked what we wanted, and why her name had been called. Her eyes returned to normal, though pupils remained small. DON notified family who consented for transfer to hospital. Ambulance called; resident left for hospital. She returned to facility at 11:50 p.m. with five staples in forehead laceration. Hourly checks are being completed on resident. -On 12/16/25 at 1:06 a.m., (recorded as a late entry) nurse evaluated R1, and DON arrived at facility. She responded to DON but due to advanced Alzheimer's did not respond to questions appropriately. R1's blood pressure noted to be slightly elevated (158/99) and son requested she be sent to ER to be evaluated. DON met ambulance at the hospital and stayed with her while she was evaluated, then accompanied her back to facility. R1 had complained of pain with movement. Two staff assisted her back to bed with gait belt and she hollered out with transfer. Morphine was administrated and staff were instructed to complete hourly checks, check bed alarm placement, and ensure bed was in lowest position. -On 12/16/25 at 7:27 a.m., R1 was restless in bed, assisted up and propelled self in wheelchair. Verbalized complaints of pain; rubbed head and sternum area with movement. -On 12/16/25 at 8:00 a.m., Call placed to on-call provider at hospital regarding increased pain and	F0600		

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F0600 SS = SQC-J	Continued from page 4 current morphine orders, will return call. -On 12/16/25 at 8:45 a.m., Difficulty with speech related to Alzheimer's repeats J-e-a n-n. Moving about in wheelchair independently on unit. Stopped frequently and rested head in palm of hand, closed eyes while rocking back and forth in chair. -On 12/16/25 at 8:51 a.m., Hospice updated. Continued to have some discomfort with abrupt movement/turning and twisting in sternal area. Rubbing at chest and head at times stating "ow". (as if in pain) -On 12/16/25 at 12:01 p.m., skin inspected: mid upper forehead laceration 3.5 cm with 5 staples. Right eyebrow with a 1 x 0.6 cm purple contusion that had a surrounding area 5 x 2 cm lighter in color. Right radial side of wrist had 4 small lacerations with some small areas of redness. Left knuckle of first finger 0.2 x 0.5 cm contusion. Left great toe 1 x 0.5 cm bruise. -On 12/16/25 at 1:34 p.m., hourly checks completed. Mid shift sleeping in wheelchair with head resting in palm of hand. Assisted to recliner then to bed. -On 12/16/25 at 2:00 p.m. Snoring while she laid in bed and difficult to arouse. -On 12/16/25 at 11:48 p.m. Condition/Status: too sleepy to get up for supper. Ate apple sauce and pocketed her medications in mouth. -On 12/18/25 at 9:00 a.m. left for appointment. -On 12/18/25 at 11:08 a.m. informed son imaging was completed without sedation. -On 12/18/25 at 1:03 p.m. Returned from clinic. Restless while she sat in wheelchair. Occasionally grimacing and stating, "ow" while moving back and forth. Orders received to increase morphine dose. -On 12/18/25 at 3:00 p.m. informed son of computed tomography (CT) scan imaging. Lidocaine patch will be	F0600		

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F0600 SS = SQC-J	Continued from page 5 placed on sternum. R1's ER visit on 12/15/25 at 10:18 p.m. identified diagnoses: laceration of scalp measured 3.5 cm, contusion of face, and multiple abrasions. R1 was placed in bed at 7:00 p.m. At 9:00 p.m. during rounds found in bed by staff with large laceration to mid upper forehead, bruise and swelling to right eyelid, and abrasion to right wrist area. She was lethargic. History of Alzheimer's unable to follow commands, provide any history of injury or answer questions (baseline according to staff present) due to advanced dementia. Received Seroquel at approximately 7:00 p.m. per staff. Dried blood noted to laceration area. Laceration was irrigated with normal saline solution, skin closure completed with five staples, and antibiotic ointment applied. Tolerated procedure well. R1's CT scan with contrast dated 12/18/25, identified acute nondisplaced (the bone breaks but maintains proper alignment) fracture (a sudden break in a bone due to a traumatic injury) of manubrial (upper part of the sternum/breastbone) (usually caused by high impact trauma such as from motor vehicle accidents, falls from heights or direct blow to the chest). Big Stone County Sheriff's Office Incident Report dated 12/24/25, identified on 12/16/25 at approximately 11:50 a.m., he was made aware of a Minnesota Adult Abuse Reporting Center (MAARC) report. Information was received and identified an investigation was warranted, cannot determine how R1 received the gash on her head or the bruising on her arm/hand. On 12/16/25 police officer (PO) completed the first interview with NA-A and identified: NA-A and NA-B had transferred R1 around 7:00 p.m., bed alarm checked and was working. At 7:45 p.m., NA-A checked on R1 sleeping, shortly before 9:00 p.m. NA-A entered R1's room and found her on the floor with cut on her head conscious and communicating, cleaned R1 up, changed her clothes, got her back to bed and sought help from trained medication aide (TMA). NA-A stated she did not immediately call for help because she was scared and did not know what to do, never got blood on her clothes, and threw the bloody rags and R1's clothing in the trash (big garbage). NA-A's second interview completed on 12/17/25 at 9:53 a.m. and identified after supper she brought R1 to her room, completed evening cares and used the lift to transfer her to toilet and to bed. NA-B completed a shower on a resident. Later that evening opened R1's door, checked on her, did not see anything unusual and	F0600		

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F0600 SS = SQC-J	Continued from page 6 closed the door. Unsure why bed alarm did not alarm or activate when R1 fell out of bed. NA-A stated she took out trash at some point (6:40 p.m.) and then placed R1's clothes in the trash after that. NA-A returned to R1's room at 8:40 p.m. and TMA arrived at R1's room at 8:53 p.m. He found it unlikely NA-A could have cleaned up R1, placed her back in bed and taken out bloody clothing/rags to the trash in less than 8 minutes. NA-A then recanted statements and informed PO what happened. R1's fall occurred after she placed her on the edge of the bed between 6:30 p.m. and 7:00 p.m. while she returned lift to bathroom and heard a thud. Wet rags were applied to stop the bleeding on R1's forehead, changed pajamas, placed her back into bed and stayed with her until she fell asleep. NA-A stated she did not immediately report the incident, feared getting in trouble for assisting R1 along, as care plan required two staff. She was afraid of losing her job, made decisions based on that fear, and did not intentionally harm R1. She later decided to report the incident because she felt it was the right thing to do. Review of NA-A's personnel file identified termination on 12/18/25, related to dishonesty. She stated she had assistance of another staff when a resident was transferred. It was discovered false and deemed a violation of the resident's care plan. It was discovered she initially disposed of the resident's bloody clothing which impacted the facility's ability to conduct an honest and ethical investigation. Camera footage also revealed she had later hidden her own hoodie which had blood on it from caring for the resident at the time of injury. She provided misinformation to cover up a wrongdoing, was unacceptable, and can cause harm to the residents. Facility 5-day report dated 12/19/25 at 3:36 p.m., identified NA-B stated she had assisted R1 with cares and placed her in bed with assist of NA-A around 7:00 p.m. At 9:00 p.m. licensed practical nurse (LPN)-A was called to R1's room for head injury. Found hematoma and 1 inch gash with bleeding. Unable to arose until sternal rub was used to stimulate her. Pupils normal and sent to ER. To ensure resident safety, her care plan was updated to include stand pivot transfer with assist of two if alert. Hoyer lift assist of two, use medium sling. R1's cognition was severely impaired. Report identified physical abuse did not occur, however concluded NA failed to follow the resident's care plan. NA-A was suspended until further notice then terminated following the conclusion of the investigation.	F0600		

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F0600 SS = SQC-J	Continued from page 7 During an observation on 12/19/15 at 1:30 p.m., R1's door was closed to her room. Knocked on the door. A female family member (FM) opened the door. R1 laid on her back in the bed, covered with blanket, with head of bed up to approximately 90 degrees, face was pale, and eyes were closed. There were at least eight people gathered in her room and FM stated she wasn't doing very well. Surveyor left the area and provided family privacy. At 1:55 p.m. R1 passed away. During an interview on 12/22/25 at 12:18 p.m. NA-C stated R1's cognition was poor, confused, and unable to communicate her needs without cues. She was not safe with assist of one staff and the EZ stand. She was uncomfortable and restless in the EZ stand, and we were expected to have two assists with transfers to be safe. She was unable to have sat on edge of bed by herself. Staff were expected to report any falls to the nurse immediately, do not move them until the nurse completed an assessment. During an interview on 12/22/25 at 1:33 p.m. NA-B stated R1 was forgetful, incredibility unsafe to be transferred with only one assist, she had taken her hands off the bars while she stood in the lift, sleepy, and had poor cognition. From 6:00 p.m. to 6:30 p.m. she gave a resident a bath. She had assisted another resident from 6:30 p.m. to 7:00 p.m. At 7:05 p.m. NA-A came out of R1's room and acted kind of weird. She asked if she was ok, and she stated she was, grabbed her sweatshirt, wrapped it around her shoulders/head and said she was hot. She asked her to assist another resident to bed and walked away. At 9:15 p.m. NA-B walked by R1's room, heard snoring, and entered the room. R1 had a huge gash on her forehead with dried blood in her hair, blood dripped down her face. NA-A stated she did not know what happened and maybe she had hit her head over there (pointed to the bar of the bed by the nightstand). R1 looked so bad. During the conversation, NA-A pointed at NA-B and said you and me transferred her together. NA-B said she stated, "oh yeah, I guess we did." NA-B said when they left the room, NA-A asked her to lie. N A-B wrote up her report and lied. R1's blood was dried onto her face, which had to have happened before 7:00 p.m. both NA-A and NA-B worked together from 7:00 p.m. to 9:00 p.m. and were not apart for more than 10 minutes. NA-A called her before there was an investigation and asked her why she freaked out and stated she did not know what happened. As soon as	F0600		

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F0600 SS = SQC-J	Continued from page 8 NA-B figured out NA-A had lied, she called the facility, told them she had lied and wanted to come clean. During an interview on 12/22/25 at 10:15 a.m., MD stated he was made aware of R1's incident/fall on 12/16/25, during a staff meeting. There were two NAs involved; one tried to cover up the fall for the other one. The staff would have been expected to follow the facility policy and report the fall and injures right away and did not happen. It was disappointing to hear how this happened, the NAs were not truthful right away. The police department was contacted and completed their own investigation. NA-A was in R1's room, transferred her, R1 then fell off the bed, and that did not get reported until two hours later. NA-A attempted to cover up the fall, changed R1's clothing, and cleaned her up. R1 ended up with a fracture to the sternum which most likely was caused by this fall, a laceration to her forehead and bruise to her eye. She was sent to ER for treatment and received stitches to her forehead. A fall with an elderly person was more serious due to possible damage to the soft tissue and fractures and would have taken longer to heal. The fall may have affected her mortality, hard to tell for sure, but was suspicious when she passed away on 12/19/25 (4 days later). During an interview on 12/22/25 at 2:25 p.m., NA-A stated R1 required assistance with all cares, safe for the most part when transferred with the EZ stand. Staff were expected to transfer R1 with assist of two for safety reasons, she struggled with understanding what was going on and required cues. She assisted R1 with supper and was administered her evening medications between 6:00 p.m. and 6:30 a.m. then fell asleep at the table. At 6:45 p.m., she pushed R1 to her room in the wheelchair and placed pajamas on her. NA-A hooked her up to the EZ stand and transferred her from wheelchair to the toilet in the bathroom alone. NA-B knew if she waited too long to put R1 to bed she would get too sleepy. She knew it was hard to understand why she transferred R1 without assistance of another staff but did it to help her. The EZ stand transfer went ok from wheelchair to toilet and toilet to bed. She kept R1 distracted which helped avoid her from becoming agitated due to lack of understanding of what was going on. NA-A lowered R1 onto the edge of the bed and removed the loops from the lift. She walked away from the bed while R1 sat alone with feet on the floor and pushed the lift machine into the bathroom. She would have been safe on the edge of the bed unattended with	F0600		

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F0600 SS = SQC-J	Continued from page 9 how awake she was and had not planned to be away from her for more than one minute. She saw R1 fall off the bed to her left side and head towards the foot of the bed and heard a thud. She ran back to the bed, rolled her over onto her back and saw blood on her forehead coming down her face by her eyebrow, and placed a pillow underneath her head. NA-A grabbed wash clothes, threw them in the bathroom sink, ran cold water over them, and placed them on R1's forehead to stop the bleeding, unsure how long, then removed them to make sure bleeding stopped. NA-A assisted R1 to sit up, R1 mumbled and asked for her sister. She removed R1's blood-stained pajama shirt and pants and replaced them with clean ones. She assisted her to a sitting position, informed her she needed to stand up, placed her heels/feet on the floor and held her back side. She positioned herself behind R1, scooped her arms underneath R1's armpits, quickly lifted her onto the bed, lifted feet up, and pivoted her into the bed onto her back. NA-A sat next to her bed, held her hand, talked to her as R1 moved her legs and mumbled. NA-A stated she just responded in the moment with a fight or flight response, felt she would have noted if she caused R1 more harm when she assisted her back to bed by herself and really thought she was ok. After that, NA-A stated she cleaned up the room, wiped four blood spots off the floor with a washcloth, bagged all her bloody clothing and wash clothes, turned off the lights, exited the room, then placed the bag in the garbage rather than launder it. At some point later NA-A indicated she went back to R1's room, touched her shoulder, she moved her leg and gave her reassurance she was ok. Then at approximately 9:00 p.m. when she was going to be leaving for the night, she knew she could not leave her with a cut on her forehead and told the first staff she saw, TMA-A. NA-A indicated she stayed with R1 while TMA-A went and found a nurse. She was asked what happened and NA-A stated she did not know. She was scared and panicked, she knew she should have got a nurse and should not been moved R1 from the floor after the fall until assessed by a nurse in case she had an injury such as a fracture. NA-A stated then NA-B entered the room and asked what happened and she was told no one knew. The registered nurse (RN)-B then asked NA-B is R1 was okay when we (NA-A and NA-B) put R1 to bed, and NA-B stated yes. RN-B and TM-A then left the room and called the director of nursing (DON). NA-A stated she then said, "you pretty much told them you helped put R1 to bed," to NA-B. NA-A indicated was asked to provide a handwritten statement prior to leaving the building. On 12/16/25, DON called and placed her on leave, and following that, she completed an interview with the city police department. On 12/19/25, she was informed	F0600		

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F0600 SS = SQC-J	Continued from page 10 she no longer had a job and was terminated. During an interview on 12/23/25 at 10:20 a.m., physical therapist (PT) stated R1 was difficult to redirect, no memory recall, and unable to carry on a constructive conversation. She had a history of falls, lacked safety awareness, and was not cognitively appropriate for therapy. The PT orders dated 10/27/25, after the evaluation was completed included assist of two with the EZ stand and was not included in the care plan. She would have not been safe sitting on the edge of the bed independently. Based upon her lack of safety awareness, she would have tried to get up and transfer herself unaware to stop herself and placed her at risk for a fall. R1 was hard to test for strength due her declined cognition. Cognition ability is what limited her to be safe in the middle of a transfer, standing, increased her risk for a fall, and the reason she required two assists with transfers. During an interview on 12/23/25 at 11:00 a.m., radiologist MD-B stated R1's results of CT scan with contrast dated 12/18/25, identified non-displaced manubrial fracture. The scan showed the fracture was acute (a break in the bone that happened recently and suddenly), no healing seen, happened within a week based on what appeared in the scan. Possibly caused by her fall directly to the floor and usually caused by direct trauma. During an interview on 12/23/25 at 3:30 p.m., RN-B stated she was called to R1's room around 9:00 p.m. regarding a fall. When she arrived in R1's room she noted a hematoma and bruising on right side of face located around the eyebrow. There was a large gash on the top of her forehead located by the hairline approximately 3 cm in length with dried blood on it and partially dried blood running down the left side of her face. She attempted to clean the gash with a gauze to better visualize the size. R1 was snoring loudly at the time, she called her name and was unable to arouse her. RN-B described R1's left eye as rolled back, and right pupil was pinpoint. RN-B stated NA-A informed her R1 was placed in bed at 7:00 p.m. and checked on at 9:00 p.m. when the gash on her head was discovered. She indicated a sternal rub was used to arouse R1 and when she woke her eyes returned to normal except the pupils remained small. The ambulance was called and R1 transferred to ER. Staff would have been expected to report the fall as soon as it happened. R1 had severely impaired cognition due to her dementia and Alzheimer's.	F0600		

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F0600 SS = SQC-J	Continued from page 11 She was an assist of two staff for transfers due to a decline in her condition and strength for safety reasons. During an interview on 12/24/25 at 8:29 a.m., DON stated R1 had advanced dementia with a recent decline and had been placed on hospice. She would not have been safe sitting on edge of bed unsupervised/independently due to the recent decline, as she was sleepy and leaning a lot. Staff were expected to provide assist of two for all transfers. R1 was not weight bearing was known to let go of the hand grippers on the EZ stand. Additionally, she was assessed by PT on 10/27/25, and identified she was two assists for transfers, but that had not gotten transcribed onto her care plan. Staff were made aware of this change during shift change rounds and verbal report. R1 required constant cueing, and mental cognition was worse in the evening. She was notified of the R1's incident on 12/15/25 at 9:10 p.m. and arrived at the facility at 9:23 p.m. R1 was evaluated, had laceration on her head, required medical treatment, cognition was poor, she mumbled the letters, "GEG, GEG" frequently (normal behavior). She was transferred to ER via ambulance. Staff were expected to report a fall as soon as possible to the nurse, evaluation/assessment completed prior to moving, repositioning, or transferring them to make sure there are no injuries or neurological abnormalities. During an interview on 12/24/25 at 8:14 a.m., PO stated he interviewed NA-A on 12/16/25 and 12/17/25 and she had changed her story. Initially NA-A wrote down NA-B assisted her with R1's transfer to bed, checked on her at 7:45 p.m. was ok, at 9:00 p.m. felt blood and reported it. PO came into facility and investigated, tested the alarms and reviewed the log. If R1 had fallen out of bed the alarm should have gone off and did not. NA-A admitted she was not truthful, stated R1 was found on the floor, which still did not make sense. He reinterviewed NA-A and she admitted she had completed a single person assisted lift. NA-A's final story identified she transferred R1 to bed, while she sat on edge of bed, placed lift in bathroom, and then heard a thud which was R1 hitting the floor. She cleaned up R1, placed her back into bed, sat with her for approximately two hours, then waited until 9:00 p.m. and reported she was injured. Based on what NA-A said PO felt the fall happened when she was on the stand lift, bruising on the back made him believe she slid through the lift and did not fall off the bed. It was believed to be an accident she attempted to cover up.	F0600		

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F0600 SS = SQC-J	Continued from page 12 During an interview on 12/24/25 at 9:35 a.m., nurse leader RN-A stated physical therapy orders were entered into the medical record system: SPT with assist of two or may use EZ stand with assist of two as needed (PRN) with a medium sling dated 10/27/25. She was responsible to enter the changes in R1's the care plan but was not completed due to human error. Staff were informed in report and aware of the need to transfer her with assist of two for safety reasons. Additionally, this information was placed on the white board by PT for staff to view. R1's MDS indicated she was dependent for transfers which indicated assist of two staff. Facility policy Falls, Fall Risk Managing dated 3/31/25, identified based on previous evaluation and current data, the staff will identify interventions related to resident risks and causes to try to prevent the resident from falling and minimize complications from falling. Resident fall risk factors that may contribute to the risk of falls include delirium and other cognitive impairment, poor grip strength, medication side effects, functional impairments, and lower extremity weakness. Facility policy Abuse Prevention dated 10/29/24, identified all residents will be free from abuse, neglect, and exploitation. Abuse was defined as the deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury harm. Neglect was defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately to administrator, licensed social worker, and the Office of Health Facility Complaints within specified time frames. Internal reporting: employees must always report any abuse or suspicion of abuse immediately to the administrator. Note: failure to report can make employee just as responsible for the abuse in accordance with State Law.	F0600		

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F0600 SS = SQC-J	Continued from page 13 Staff education dated 12/16/25, Abuse, Neglect/Accident reporting and following care plan. Incident Overview: Allegation of neglect, delayed injury reporting and not following care plan. Reporting Delay: Not reported immediately to supervisor or location leaders. Details: Staff did not follow the care plan for type of lift required for resident transfers resulting in resident injury and not reported to supervisors/leaders immediately. For any injury to a resident, always report immediately to ensure proper assessment, first aid and necessary notifications to physician, family, and possible authorities. In the event of resident fall or accident with any lift, do not move resident, stay with resident and summon the licensed nurse. A nurse must observe the resident and perform a full-body exam to determine if there maybe suspected injury and direct whether to move the resident. Nursing staff are expected to follow the resident care plan for guidance on assistance with daily activities, including transfers: type of lift, size of sling or harness, and number of staff required to assist the resident to reduce risk of injury. The past noncompliance immediate jeopardy began on 12/15/25. The immediate jeopardy was removed and the deficient practice corrected by 12/18/25 after the facility implemented a systemic plan that included the following actions: -Investigated the circumstances around R1's injuries and implemented immediate resident protection. -R1's Care Plan was revised to include stand pivot transfer with assist of two if alert. Hoyer lift, assist of two with medium sling. -Re-educated the staff on Abuse/Neglect/Accident Reporting, providing safe and appropriate care, and resident protection. -Education verified through interview and training records. The facility implemented corrective actions prior to the start of survey on 12/19/25 and therefore this is issued in past noncompliance.	F0600		

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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 12/19/25, and 12/22/25 through 12/24/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was reviewed. H54511520C (2694007). No licensing orders were issued. Minnesota Department of Health is documenting the State	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 Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		