Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 21, 2025

Administrator
Minnewaska Community Health Services
605 MAIN STREET
PO BOX 40
STARBUCK, MN 56381

RE: CCN: 245537
Cycle Start Date: July 1, 2025

Dear Administrator:

On August 1, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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Electronically delivered

November 21, 2025

Administrator
Minnewaska Community Health Services
605 MAIN STREET
PO BOX 40
STARBUCK, MN 56381

Re: Reinspection Results
Event ID: GNRO-H2

Dear Administrator:

On August 1, 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 July 1, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

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An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 10, 2025

Administrator
Minnewaska Community Health Services
605 Main Street
Starbuck, MN 56381

RE: CCN: 245537
Cycle Start Date: July 1, 2025

Dear Administrator:

On July 1, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction

occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 1, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 1, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the

same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 10, 2025

Administrator
Minnewaska Community Health Services
605 Main Street
Starbuck, MN 56381

Re: State Nursing Home Licensing Orders
Event ID: GNRO11

Dear Administrator:

The above facility was surveyed on June 30, 2025 through July 1, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245537	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minnewaska Community Health Services	**605 MAIN STREET PO BOX 40, STARBUCK, Minnesota, 56381**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 6/30/25 to 7/1/25, 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 complaint was reviewed H55378167C (MN00114174), with a deficiency cited at F686. 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		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional	F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. R1 was a discharged resident at the time of survey, resident did not return. All residents assessed (including R2,R3) to ensure that skin was intact, care plans were updated accordingly. The DON conducted training for all licensed nursing staff. All licensed nursing staff will be educated by	07/19/2025

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: 245537	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0686 SS = D	Continued from page 1 standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to implement daily monitoring and assessment of a deep tissue injury (a type of pressure ulcer, a serious condition that affects the underlying layers of skin, muscle and other soft tissues) for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: R1's admission Minimum Data Set (MDS) dated 6/2/25, identified R1 had moderate cognitive impairment and diagnoses which included: diabetes mellitus, cerebral vascular accident (stroke) and anxiety. R1 required partial/moderate assistance with toilet use, hygiene, and substantial/maximal assistance with dressing and transfers. R1 was at risk for pressure ulcers and had no unhealed pressure ulcers. R1's Pressure Ulcer Care Area Assessment (CAA) dated 6/5/25, identified R1 was at risk for potential pressure ulcers and R1's skin was assessed each week by a nurse, and by caregivers with each bath and each time R1 was dressed. Identified interventions were in place to prevent skin break down. R1 would be assisted with repositioning at least every two hours and as needed for comfort. R1's Braden Scale - for Predicting Pressure Ulcer Risk Evaluation dated 6/11/25, identified R1 had a score of 14, which identified R1 was at moderate risk for pressure ulcers. R1's Weekly Wound Round Documentation dated 6/20/25 at 11:21 a.m., identified R1 had a pressure wound acquired 6/20/25. The pressure wound was located on R1's sacrum (area at base of the spine) with length of 6 centimeters (cm), 4 cm width, no depth, and staged as a suspected deep tissue injury. The assessment identified no drainage and surrounding tissue was intact. Current treatment plan was moisture barrier, mattress air overlay and wheelchair/Broda chair (large adjustable cushioned wheel chair) cushion. The assessment identified no pain or odor.	F0686	Continued from page 1 7.19.25 to ensure all pressure ulcers are monitored and assessed daily including evaluation of the wound bed if dressing not present, dressing status, description of wound edges and surrounding tissue, pain, location and staging. Nursing staff also educated on pressure injury prevention and management policy. The DON or designee will audit the Electronic Health Record to ensure daily monitoring and assessment of pressure ulcers is being completed and policies are being followed. The QAA committee will review audit results and recommend further improvements/audits as needed Completion Date: 07/19/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245537	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2025

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F0686 SS = D	Continued from page 2 R1's care plan revised 6/23/25, identified R1 had a potential for activities of daily living (ADL) self-care performance deficit with interventions which included assistance of one with bathing, bed mobility, dressing, and grooming. R1's care plan identified R1 had limited physical mobility and required Hoyer (mechanical lift) for all transfers. R1 had actual impairment to skin integrity related to mechanical forces, impaired physical mobility, knowledge deficit and impaired circulation/perfusion, as evidenced by (AEB) tissue damage, changes in appearance of the affected area. Interventions included mattress air overlay, required (pressure relieving/reducing mattress, pillows, sheepskin padding etc) to protect the skin while in chair/wheelchair or bed, and weekly documentation. R1's progress notes reviewed 6/1/25 to 7/1/25, identified the following: -6/20/25, at 10:55 a.m., skilled evaluation: R1's skin: 1. The note identified the number one and lacked any further documentation. -6/21/25 at 1:10 a.m., skilled evaluation: R1's skin warm and dry, skin color WNL and turgor is normal. -6/21/25 at 11:33 a.m., skilled evaluation: R1's skin warm and dry, skin color WNL and turgor is normal. Skin issue # 001-identified as: new skin issue, sacrum, type, bruising, unknown how long the wound had been present. Painful yes, no measurements documented as part of the assessment, with reason as not applicable (n/a). -6/22/25 at 6:00 a.m. skilled evaluation: R1's skin issue #001- had not been evaluated. -identified as: new skin issue, sacrum, type, bruising, unknown how long the wound had been present -6/22/25 at 2:06 p.m., skilled evaluation: R1's skin issue #001- had not been evaluated. -identified as: new skin issue, sacrum, type, bruising, unknown how long the wound had been present -6/22/25 at 6:49 p.m., skin check: delegated to night	F0686		

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F0686 SS = D	Continued from page 3 nurse. -6/22/25 at 10:56 p.m., skilled evaluation: -R1's skin issue #001- had not been evaluated. -identified as: new skin issue, sacrum, type, bruising, unknown how long the wound had been present. -6/23/25 at 12:02 p.m. R1 sent to emergency room due to change in level of cognition (LOC) and required oxygen to keep sats over 88%. R1's medical record lacked documentation of daily monitoring of R1's pressure ulcer, including: if pain present, location, staging, size, drainage, description of wound bed, wound edges and surrounding tissue. Review of R1's emergency room attending physician's progress notes dated 6/23/25, identified a severe decubitus ulcer, sacral region unspecified stage. During interview on 6/30/25 at 2:03 p.m., nursing assistant (NA)-A stated NA-A had notified the nurse, case manager and director of nursing (DON) on 6/20/25, that R1 had a dark bruise area on her sacral area, and DON assessed it. During interview on 7/1/25 at 8:16 a.m., registered nurse (RN)-A stated RN-A had become aware of R1's deep tissue injury on 6/20/25, and notified DON. RN-A confirmed she had sent R1 to the emergency room on 6/23/25, and had not observed or assessed R1's pressure ulcer. RN-A said her usual practice for when to monitor pressure ulcers, was when completing dressing changes, or to check to assure the dressings were intact. RN-A stated DON completed all other wound assessments weekly as the wound nurse. During interview on 7/1/25 at 8:45 a.m., DON stated she was the facility wound nurse. DON confirmed she had been informed by the nursing staff on 6/20/25, that R1 had an darkened area on sacrum. DON reviewed R1's progress notes with skin assessments, and indicated she was not aware why some of the assessments were identified as no skin issues, or not evaluated. In addition, DON indicated she did not know what the number one represented in the skin progress notes listed above. DON indicated her expectation was that	F0686		

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Minnewaska Community Health Services	**605 MAIN STREET PO BOX 40, STARBUCK, Minnesota, 56381**

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F0686 SS = D	Continued from page 4 staff assessed pressure ulcers daily or every shift when competing skilled nursing assessments. During a telephone interview on 7/1/25 at 10:36 a.m. , RN-B indicated he thought he evaluated R1's deep tissue injury when observing R1 while she was in bed. RN-B was unable to describe the wound however, thought it looked kind of blackish, was not open and stated he could not remember for certain. RN-B stated there were no orders to observe R1's wound or any treatment plan. During a telephone interview on 7/1/25 at 11:37 a.m., RN-C indicated RN-C had been aware of R1's pressure ulcer and had documented it in R1's skills assessment and stated there was a place to check if there was no change. RN-C stated when RN-C had viewed R1's pressure ulcer, it was intact. During a telephone interview on 7/1/25 at 11:45 a.m. licensed practical nurse (LPN)-A indicated LPN-A had not been aware R1 had a pressure ulcer, until after R1 had been sent to the hospital. LPN-A stated R1 did not have any orders on her treatment administration record (TAR) to assess or treat a pressure ulcer. During a follow up interview on 7/1/25 at 11:29 a.m., DON indicated if a resident was receiving skilled services, the nurses were expected to assess the resident's skin each shift on the resident's skilled evaluation. DON stated if a long term resident had a pressure ulcer, she would place a nursing order in the electronic health record for nurses to assess the pressure ulcer daily. Review of the facility policy Pressure Injury Prevention And Management Policy dated 1/1/25, identified licensed nurses would conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings would be documented in the medical record. The policy identified monitoring would be completed by weekly wound assessments until resolved. The facility policy lacked identification of required daily monitoring of pressure ulcers.	F0686		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/01/2025**

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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 6/30/25 to 7/1/25, 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 orders 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		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/01/2025**

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Minnewaska Community Health Services	**605 MAIN STREET PO BOX 40, STARBUCK, Minnesota, 56381**

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20000	Continued from page 1 The following complaints were reviewed: H55378167C (MN00114174) with a licensing order issued at 0900. 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 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		
20900	Rehab - Pressure Ulcers CFR(s): MN Rule 4658.0525 Subp. 3 Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:	20900	corrected.	07/19/2025

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20900	Continued from page 2 A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to implement daily monitoring and assessment of a deep tissue injury (a type of pressure ulcer, a serious condition that affects the underlying layers of skin, muscle and other soft tissues) for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: R1's admission Minimum Data Set (MDS) dated 6/2/25, identified R1 had moderate cognitive impairment and diagnoses which included: diabetes mellitus, cerebral vascular accident (stroke) and anxiety. R1 required partial/moderate assistance with toilet use, hygiene, and substantial/maximal assistance with dressing and transfers. R1 was at risk for pressure ulcers and had no unhealed pressure ulcers. R1's Pressure Ulcer Care Area Assessment (CAA) dated 6/5/25, identified R1 was at risk for potential pressure ulcers and R1's skin was assessed each week by a nurse, and by caregivers with each bath and each time R1 was dressed. Identified interventions were in place to prevent skin break down. R1 would be assisted with repositioning at least every two hours and as needed for comfort. R1's Braden Scale - for Predicting Pressure Ulcer Risk Evaluation dated 6/11/25, identified R1 had a score of 14, which identified R1 was at moderate risk for pressure ulcers. R1's Weekly Wound Round Documentation dated 6/20/25 at 11:21 a.m., identified R1 had a pressure wound acquired	20900		

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20900	Continued from page 3 6/20/25. The pressure wound was located on R1's sacrum (area at base of the spine) with length of 6 centimeters (cm), 4 cm width, no depth, and staged as a suspected deep tissue injury. The assessment identified no drainage and surrounding tissue was intact. Current treatment plan was moisture barrier, mattress air overlay and wheelchair/Broda chair (large adjustable cushioned wheel chair) cushion. The assessment identified no pain or odor. R1's care plan revised 6/23/25, identified R1 had a potential for activities of daily living (ADL) self-care performance deficit with interventions which included assistance of one with bathing, bed mobility, dressing, and grooming. R1's care plan identified R1 had limited physical mobility and required Hoyer (mechanical lift) for all transfers. R1 had actual impairment to skin integrity related to mechanical forces, impaired physical mobility, knowledge deficit and impaired circulation/perfusion, as evidenced by (AEB) tissue damage, changes in appearance of the affected area. Interventions included mattress air overlay, required (pressure relieving/reducing mattress, pillows, sheepskin padding etc) to protect the skin while in chair/wheelchair or bed, and weekly documentation. R1's progress notes reviewed 6/1/25 to 7/1/25, identified the following: -6/20/25, at 10:55 a.m., skilled evaluation: R1's skin: 1. The note identified the number one and lacked any further documentation. -6/21/25 at 1:10 a.m., skilled evaluation: R1's skin warm and dry, skin color WNL and turgor is normal. -6/21/25 at 11:33 a.m., skilled evaluation: R1's skin warm and dry, skin color WNL and turgor is normal. Skin issue # 001-identified as: new skin issue, sacrum, type, bruising, unknown how long the wound had been present. Painful yes, no measurements documented as part of the assessment, with reason as not applicable (n/a). -6/22/25 at 6:00 a.m. skilled evaluation: R1's skin issue #001- had not been evaluated. -identified as: new skin issue, sacrum, type, bruising, unknown how long	20900		

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20900	Continued from page 4 the wound had been present -6/22/25 at 2:06 p.m., skilled evaluation: R1's skin issue #001- had not been evaluated. -identified as: new skin issue, sacrum, type, bruising, unknown how long the wound had been present -6/22/25 at 6:49 p.m., skin check: delegated to night nurse. -6/22/25 at 10:56 p.m., skilled evaluation: -R1's skin issue #001- had not been evaluated. -identified as: new skin issue, sacrum, type, bruising, unknown how long the wound had been present. -6/23/25 at 12:02 p.m. R1 sent to emergency room due to change in level of cognition (LOC) and required oxygen to keep sats over 88%. R1's medical record lacked documentation of daily monitoring of R1's pressure ulcer, including: if pain present, location, staging, size, drainage, description of wound bed, wound edges and surrounding tissue. Review of R1's emergency room attending physician's progress notes dated 6/23/25, identified a severe decubitus ulcer, sacral region unspecified stage. During interview on 6/30/25 at 2:03 p.m., nursing assistant (NA)-A stated NA-A had notified the nurse, case manager and director of nursing (DON) on 6/20/25, that R1 had a dark bruise area on her sacral area, and DON assessed it. During interview on 7/1/25 at 8:16 a.m., registered nurse (RN)-A stated RN-A had become aware of R1's deep tissue injury on 6/20/25, and notified DON. RN-A confirmed she had sent R1 to the emergency room on 6/23/25, and had not observed or assessed R1's pressure ulcer. RN-A said her usual practice for when to monitor pressure ulcers, was when completing dressing changes, or to check to assure the dressings were intact. RN-A stated DON completed all other wound assessments weekly as the wound nurse.	20900		

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20900	Continued from page 5 During interview on 7/1/25 at 8:45 a.m., DON stated she was the facility wound nurse. DON confirmed she had been informed by the nursing staff on 6/20/25, that R1 had an darkened area on sacrum. DON reviewed R1's progress notes with skin assessments, and indicated she was not aware why some of the assessments were identified as no skin issues, or not evaluated. In addition, DON indicated she did not know what the number one represented in the skin progress notes listed above. DON indicated her expectation was that staff assessed pressure ulcers daily or every shift when competing skilled nursing assessments. During a telephone interview on 7/1/25 at 10:36 a.m. , RN-B indicated he thought he evaluated R1's deep tissue injury when observing R1 while she was in bed. RN-B was unable to describe the wound however, thought it looked kind of blackish, was not open and stated he could not remember for certain. RN-B stated there were no orders to observe R1's wound or any treatment plan. During a telephone interview on 7/1/25 at 11:37 a.m., RN-C indicated RN-C had been aware of R1's pressure ulcer and had documented it in R1's skills assessment and stated there was a place to check if there was no change. RN-C stated when RN-C had viewed R1's pressure ulcer, it was intact. During a telephone interview on 7/1/25 at 11:45 a.m. licensed practical nurse (LPN)-A indicated LPN-A had not been aware R1 had a pressure ulcer, until after R1 had been sent to the hospital. LPN-A stated R1 did not have any orders on her treatment administration record (TAR) to assess or treat a pressure ulcer. During a follow up interview on 7/1/25 at 11:29 a.m., DON indicated if a resident was receiving skilled services, the nurses were expected to assess the resident's skin each shift on the resident's skilled evaluation. DON stated if a long term resident had a pressure ulcer, she would place a nursing order in the electronic health record for nurses to assess the pressure ulcer daily. Review of the facility policy Pressure Injury Prevention And Management Policy dated 1/1/25, identified licensed nurses would conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly	20900		

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20900	Continued from page 6 identified pressure injury. Findings would be documented in the medical record. The policy identified monitoring would be completed by weekly wound assessments until resolved. The facility policy lacked identification of required daily monitoring of pressure ulcers. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could conduct training for all staff to ensure all pressure ulcers are monitored and assessed daily, including evaluation of the wound bed if dressing not present, dressing status, description of wound edges and surrounding tissue , pain, location and staging. The DON or designee could monitor to ensure daily montioring and assessment is completed and polices are being implemented. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	20900		