Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 4, 2026

Administrator
SUNNYSIDE CARE CENTER
16561 US HIGHWAY 10
LAKE PARK, MN 56554

RE: CCN: 245597
Cycle Start Date: April 17, 2026

Dear Administrator:

On May 7, 2026, we notified you a remedy was imposed. On June 3,2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 1, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 17, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 7, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 17, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 1, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

May 7, 2026

Administrator
SUNNYSIDE CARE CENTER
16561 US HIGHWAY 10
LAKE PARK, MN 56554

RE: CCN: 245597

Cycle Start Date: April 17, 2026

Dear Administrator:

On April 17, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 17, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 17, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 17, 2026.

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

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

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

NURSE AIDE TRAINING PROHIBITION

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

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/ Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 17, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 17, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will

not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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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May 7, 2026

Administrator
SUNNYSIDE CARE CENTER
16561 US HIGHWAY 10
LAKE PARK, MN 56554

Re: Event ID: 22E4C8-H1

Dear Administrator:

The above facility survey was completed on April 17, 2026 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,

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: 245597	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 , LAKE PARK, Minnesota, 56554

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 4/16/26 and 4/17/26, 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 H55971168C (2977682) with a deficiency issued at F689 past noncompliance. As a result of the compliant investigation, an incidental finding was cited at F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		06/01/2026
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to implement standards of	F0689	"Past Noncompliance - no plan of correction required"	04/17/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245597	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/17/2026

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F0689 SS = G	Continued from page 1 practice to ensure a safe transfer for 1 of 3 residents (R1) reviewed for accidents. This resulted in actual harm when R1 fell from the lift during a staff assisted transfer, sustained a small subarachnoid hemorrhage, hematoma and open wound at back of head, prominent soft tissue swelling and bruising of the right elbow, was sent to the emergency department (ED), admitted to the hospital, required overnight neurological monitoring, wound care and pain control. The facility implemented corrective action, so the deficient practice was issued at past non-compliance. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/23/26, identified he was admitted to facility on 9/3/25, from a skilled nursing facility. R1 had difficulty communicating some words or finishing thoughts but was able if prompted or given time and had unclear speech. R1 had severely impaired cognition, never/rarely made decisions, and no behaviors. R1 was dependent upon staff for oral/toileting/personal hygiene, dressing, all transfers, used a wheelchair for mobility, and had impaired /functional limitations in range of motion of both upper and lower extremities bilaterally. Diagnoses included: cerebrovascular accident (CVA) (stroke), anemia (low red blood cells), and aphasia (a disorder that affects your ability to speak and understand what others say to you). R1 had no falls or skin conditions since admission. R1's care plan dated 4/13/26, identified: Activities of daily living (ADL) self-care deficit related to hemiplegia (one sided paralysis or weakness) of the right side due to CVA. R1 was dependent upon staff for all cares and transfers. Staff were directed to transfer R1 with assist of two, Hoyer lift (brand of full body mechanical lift), using a medium sling/beige in color. R1 was at moderate risk for falls related to poor communication/comprehension, unaware of safety needs, and impaired mobility. Staff were directed to anticipate needs, use safe transfer techniques, mobility aids, and monitor for changes in condition, reassess fall risk on a regular basis, address contracture thorough positioning and range of motion exercises. R1 had actual fall from lift. Staff were directed to check range of motion daily and monitor/document/report as needed (PRN) to medical doctor (MD) signs/symptoms (s/sx): pain, bruises, change in mental status, new onset of confusion, sleepiness, inability to maintain posture,	F0689		04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245597	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/17/2026

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SUNNYSIDE CARE CENTER	**16561 US HIGHWAY 10 , LAKE PARK, Minnesota, 56554**

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F0689 SS = G	Continued from page 2 and agitation. R1 had an alteration in musculoskeletal status related to (r/t) contracture of the left forearm, left hand, and right lower leg. Staff were directed to anticipate needs, place call within reach, respond quickly, and encourage the use of supportive devices: hand and leg braces, and wedge in wheelchair as recommended. R1 received antiplatelet medication, Aspirin (ASA). Staff were directed to monitor skin for bruising, sudden severe headaches, and sudden change in mental status. R1 was started on Narcotic/Tramadol on 4/10/26 related to acute pain due to dressing changes on injuries from fall. Staff were directed to administer medication as ordered by provider, monitor/document for side effects and effectiveness every shift. Chronic pain r/t contractures. Staff were directed to administer Tylenol as ordered and administer half-hour before treatments of care and evaluate effectiveness. R1 had potential impairment to skin. Staff were directed to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces. R1's Fall Risk Assessment dated 3/10/26 at 10:34 a.m., identified no history of falls, unable to ambulate, bedrest/wheelchair, and aware of limits. R1's fall risk score was 35 (moderate risk 25-44). R1's physician orders identified: Order date 9/5/25, Aspirin 81 milligrams (mg) oral tablet chewable one tablet via g-tube one time a day for cerebral infarction (stroke). May give orally or via g-tube. Order date 4/10/26, Tramadol Hydrochloride (HCL) oral tablet 50 mg by mouth two times a day for pain. Order date 4/10/26, Tramadol Hydrochloride (HCL) oral tablet 50 mg by mouth every four hours as needed (PRN) for pain, must be least four hours from scheduled dose. Order date 4/10/26, Scalp Wound: clean with wound cleaner or soap and water. Apply Adaptec or petroleum dressing, gauze and kerlix. Elbow Wound:	F0689		04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245597	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/17/2026

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F0689 SS = G	Continued from page 3 only change every 14 days unless increased drainage, peeling of dressing or dressing loses integrity, then ok as needed (PRN). Clean with wound cleaner or soap and water. Apply versatile one (silicone contact layer), gauze, kerlix and ACE wrap PRN. May rewrap as needed. Remove dressing to shower and change dressing PRN to keep clean, dry and intact. Order date 4/16/26, Right elbow: clean with Vashe (would cleanser) soak two minutes between each dressing change. Dress with Mepilex, change every three days and PRN for drainage. You may remove the Mepilex to check the wound in between the three days and/or clean the wound. Reapply the same bandage if not too soiled after doing this. Place Tubi grip (an elastic tubular bandage), on the right arm over the Mepilex every day shift every three days for wound cares. Order date 4/16/26, Scalp: wash with Vashe soaked gauze for two to five minutes daily. After soaking, try to remove scab gently if it lifts away easily otherwise leave alone. Once cleaned and debrided if able, place Adaptec gauze over the wound, then 4 x 4's, and secure around the head with a roll of soft roll gauze. Change dressing daily for wound care. ED provider notes dated 4/8/26 at 9:15 a.m., identified R1 presented to ED following a witnessed fall from a Hoyer lift. It was reported he fell backwards out of the back of it hitting back of head causing laceration on back of head and abrasion on right elbow with no loss of consciousness. R1 winced in pain when back of head was cleaned. Medical Decision Making: CT scan of spine and abdomen negative, CT of head revealed tiny amount of subarachnoid blood products about the left frontal lobe, and x-ray of right elbow negative for fracture but showed soft tissue swelling. Neurosurgery recommended holding aspirin and outpatient follow-up. No neurosurgery interventions needed. Given R1 was non-verbal status, and large hematoma will be admitted overnight to hospital for neuro status monitor and repeat head CT. Admitted to hospital observation on 4/8/26 at 2:23 p.m., and discharged back to facility on 4/9/26 at 2:52 p.m. R1's CT of head without contrast dated 4/8/26 at 9:23 a.m., impression: tiny amount of subarachnoid blood products about the left frontal lobe. No significant mass effect or midline shift. Contusion/laceration overlying the right parietal and occipital bones without underlying fracture.	F0689		04/17/2026

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F0689 SS = G	Continued from page 4 R1's CT scan of right elbow without contrast dated 4/8/26 at 12:16 p.m., impression: prominent soft tissue swelling about the lateral epicondyle (the bony prominence on the outer side of the humerus at the elbow) without displaced elbow fracture accounting for limitations. Medial and lateral epicondylar enthesophytes (bony spurs (calcifications) at the elbow where tendons attach). Surgical consult dated 4/9/26 at 11:55 a.m., identified he was seen for a surgical evaluation regarding wound care to the scalp and right elbow. R1 fell out of the sling during a transfer yesterday, hit his head, and sustained a small subarachnoid hemorrhage (bleeding in the space between the brain and the tissues that cover the brain). There was quite a bit of bleeding. Wounds were not bleeding. Examination identified hematoma (trauma to the blood vessels causing a collection of blood under the skin) to the right posterior scalp with a small opening at the base and right elbow skin tear well adhered to the skin underneath with granulation tissue at the base of the wound. No drainage or bleeding noted. Dressed the scalp with Adaptec, gauze, kerlix, and elbow with versatile one (silicone contact layer), gauze, kerlix, and ACE wrap loosely. Plan: change dressings daily and clean wounds with wound cleaner or soap and water. R1's Weekly Wound Round Documentation dated 4/10/26, at 9:11 a.m., identified a new wound was acquired on 4/8/26, small subarachnoid hemorrhage after fall, hematoma developed with open wound and drainage at back of head on right side. Wound measured 3 cm length, 1.5 cm with, 1 cm depth, and stage: none with minimal serosanguineous (thin, watery, pale, red/pink) drainage. Current treatment plan: clean with wound cleaner or soap and water. Apply Adaptec, gauze, and kerlix. Pain level 3/10. R1's Weekly Wound Round Documentation dated 4/10/26 at 9:17 a.m., identified a new wound was acquired on 4/8/26, bruising and swelling to right elbow with skin tear. Wound measured 2 cm in length, 1.5 cm width, 0 depth, and stage: none with no drainage. No active bleeding noted, clear versatile dressing remained intact, dried dark blood noted under clean dressing. No s/s of infection. Current treatment plan: see right elbow order. Pain level 3/10. Positioning plan: elevate elbow and apply ice. R1's progress noted dated from 4/8/26 through 4/10/26, identified:	F0689		04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245597	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/17/2026

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F0689 SS = G	Continued from page 5 On 4/8/26 at 8:25 a.m., R1 was being transferred from bed to wheelchair following bath and ADL assistance with two nursing assistants (NA's). Sling was placed under resident and attached to Hoyer lift. While resident was being transferred, fell out of the sling and landed on his right side hitting his head and sustained a laceration to back of right head and right elbow. Pressure applied to laceration and emergency medical services (EMS) was called, arrived and transferred R1 to emergency department (ED) for evaluation. Family and primary care provider updated on incident. On 4/8/26 at 2: 33 p.m., R1 evaluated in ED following incident of fall out of Hoyer lift. Computed tomography (CT) scan (combination of x-rays and computer to see inside the body) of head showed "tiny amount of subarachnoid blood products about [sic] the left frontal lobe. No significant mass effect or midline shift. Contusion/laceration overlying the right parietal and occipital bones without underlying fractures. R1 was admitted. Medical doctor (MD) stated "given nonverbal status and large hematoma will admit overnight to hospital for Nereo status monitoring and repeat head CT." On 4/9/26 at 2:24 p.m., readmission after one night stay at local hospital. Diagnoses: small subarachnoid hemorrhage with scalp hematoma and skin tear to right elbow after fall from Hoyer lift. Nurse to nurse report received from hospital nurse. Attempted magnetic resonance imaging (MRI) (magnetic waves used to create detailed 3D images of soft tissues, organs, and bones) and did not tolerate and CT scan of right elbow was competed with no displaced fracture resulted. No changes in neurological status since admission and denied pain. On 4/9/26 at 10:25 p.m., New skin issue #1: right elbow, open lesion, acquired in-house. Length 4.5 cm x depth 3 cm, dressing appearance: leaking, dressing saturated 25%. New skin issue #2: rear scalp laterally, laceration, partial or complete separation of the outer layers of the joined incision, closure method other: 4 x 4's wrapped head with gauze. Painful: yes, leaned forward in wheelchair. Length 4.5 cm x with 3.0 cm. Daily treatments. New skin issue #3: right elbow bruising acquired in house. Length 4 cm x width 3.5 cm. Dressing changed to head, lots of dried blood, lots of dried blood, writer attempted to clean, redressed wound after lightly cleansed. Bruising and hematoma present. Dressing change: area cleansed, and dressing applied. On 4/10/26 at 1:45 p.m., telehealth zoom visit	F0689		04/17/2026

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F0689 SS = G	Continued from page 6 completed with R1 and primary provider regarding follow-up after fall from Hoyer lift. R1 had a head and right elbow injuries. Discussed pain management especially during heavy care times. Sent order for Tramadol. On 4/10/26 at 5: 36 p.m., applied ice pack to right elbow two times today for 20 minutes each time d/t pain, swelling and bruising at right elbow. Tolerated well.. Facility five-day report submitted on 4/10/26 at 1:14 p.m., identified two nursing assistants (NAs) assisted R1 with ADLs following a bath. The lift sling was placed under R1 and attached to the lift. [NA]-A started to raise R1 off the bed when both NAs heard the sling “adjust.” The NAs rechecked all loops of the sling were on the hooks of the lift and reported they were. [NA-A] continued to raise R1 off bed to transfers to wheelchair. [NA-B] started to guide R1’s feet off the bed when he suddenly dropped to the floor. R1’s head and shoulder fell to the ground with feet stayed in the sling. NAs quickly removed his feet from the sling and assisted him to the ground. Help was called and licensed practical nurse [LPN]-A arrived immediately. Pressure was applied to laceration on back of head on right side and right elbow. [LPN-A] instructed [NA-B] to get director of nursing (DON). DON arrived at room and called 911. R1 laid on floor alert and shock head yes/no when asked questions. No clutter or debris around R1, floor was dry, no concerns for the environment being a factor in incident. Vital signs and assessment completed until EMS arrived. R1 was admitted to the hospital for observation following incident. R1 injuries included: tiny amount of subarachnoid blood products about the left frontal lobe, prominent soft tissue swelling about the lateral elbow without discrete displaced underlying fracture, and no nor changes noted. Facility investigation was inconclusive and unable to determine the cause of the fall from the full body lift. Care plan was followed, two staff assisted with transfer, proper lift sling (medium) was used, free from rips, tears and in good condition, lift was inspected by maintenance department after incident and found to be in full working order. R1’s general surgery consult dated 4/16/26, identified R1 presented for follow-up for wound care after a fall a little over a week ago, sustained an elbow laceration as well as a scalp hematoma and hospitalized. R1’s head hematoma was located to the right posterior scalp, scab was noted to be over the wound, no bleeding or pain on palpation, and no signs of infection during exam. R1’s right elbow	F0689		04/17/2026

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F0689 SS = G	Continued from page 7 skin tear had granulation tissue at the base of the wound, no drainage, small amount of bleeding with manipulation, no signs of infection, swelling of the right arm and resolving ecchymosis (bruising). The wounds were cleaned and mechanically debrided. Hair trimmed around scalp wound to aid in wound healing and keep hair out of wound. Wound care orders and instructions were provided (see orders above). Return visit in about one week around 4/23/26. R1's electronic medication administration record (EMAR) April 2026, identified: Acetaminophen extra strength oral tablet 500 mg give two tablets via g-tube three times a day for pain. From 4/1/26 through 4/8/26, R1 was administered Acetaminophen 1000 mg three times a day for a total of 21 times with pain rated at 0/10 (20 times) and 2/10 (one time). From 4/9/26 through 4/26/26, R1 was administered 1000 mg three times a day for a total of 21 times with pain rated at 0/10 thirteen times, 1/10 two times, 2/10 one time, 3/10 four times, 4/10 one time. Tramadol HCL 50 tablet give by mouth two times a day for pain, administered as scheduled a.m. and p.m. shifts, 12 times from 4/10/26 through 4/16/26. Tramadol HCL 50 mg tablet give by mouth every four hours PRN for pain and must be at least four hours from scheduled dose. Administered one time on 4/13/26 at 4:23 p.m. pain level rated at 3/10. During an interview/observation on 4/16/26 at 9:25 a.m., primary provider nurse practitioner (NP) stated R1 had vascular dementia, expressive aphasia, no decision making compacity and his wife was his guarantee. Since R1's severe complex stroke he was severely contracted, very ridged with no mobility, dyskinesia identified by slow or involuntary movements with possible involuntary spasms, and placed him at high risk for falls. R1 had a history of seizures without seizure activity and on high-risk medications. R1 had a fall from the lift, some type of mechanism where he did not remain in the lift. R1's mobility did not contribute to the fall. NP was notified immediately and R1 was sent to emergency room (ER). R1 did not lose consciousness and diagnosed with a subarachnoid hemorrhage, occipital and skin abrasions, hematoma, and required dressing changes. R1's right arm/elbow area was very tender, and he displayed non-verbal cues of discomfortable/pain. R1 was started on pain management for the dressing changes. At 9:37 a.m., observation identified NP visited R1 in his room and	F0689		04/17/2026

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F0689 SS = G	Continued from page 8 completed an examination. R1 sat in wheelchair fully dressed in pressure relieving boots on both feet. NP pulled down the dressing located on R1's right elbow and examined the hematoma approximate size of a quarter, dark purple with moderate amount of red/bloody drainage on dressing. At 9:45 a.m. unidentified staff entered the room and stated R1 had an appointment at the clinic now for right elbow injury and removed him from the room in his wheelchair. During an observation on 4/16/26 at 2:00 p.m., NA-A brought lift machine and medium sling into room #113 and demonstrated how she transferred R1 on 4/8/26, with the same lift. NA-A stated a medium sized tan sling with dark gold trim was used for the lift transfer per R1's care plan. R1 had received a bath, laid in bed, bath sling was removed and R1 was dressed for the day. NA-B assisted with transfer and stood on the left side of the bed by the window. R1's wheelchair was in the corner of the room over by the window. The medium lift sling was placed underneath R1 with the top of the sling positioned about five inches below his shoulders so that the bottom of the sling covered his bottom, (demonstrated on surveyor the placement of the sling), and crisscrossed sling between his legs. NA-A pushed the hoyer lift over the bed, legs closed, and brakes on bed. NA-A hooked up the sling loops to the lift bar on R1's right side: placed short black loop on top and the longer dark tan loop on top of the black loop (doubled looped). Then, NA-A hooked up the right lower long dark tan colored loop to the lift bar. NA-B hooked up the left side sling loops the same. NA-A stated she used the lift controls and lifted R1 up, then heard a noise, "like the black loop on the upper side and the sling were adjusting to his [R1's] body weight. We heard the loop pop down, I [NA-A] stopped raising him [R1] up, I checked the loops, and all were connected to the metal bar of the lift." NA-A lifted R1 off the bed except for his feet with the hoyer lift, and pulled back the lift until R1 was off the bed. NA-A waited for NA-B to come around the end of the bed. NA-B swung R1's feet off the bed, and faced away from the lift. NA-A stated "He [R1] hit the ground hard. He had blood coming from the back of his head and right elbow." R1 was able to respond and shook his head yes when she asked if he was okay. Once R1 hit the floor his legs hung in the sling attached to the hoyer lift. NA-A did not remove the upper short black loops, only the long loops of the sling from the machine and lowered his legs down to the floor and yelled for a nurse. A staff nurse and DON came to R1's room, stayed with him while he laid on the floor, NA-A	F0689		04/17/2026

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F0689 SS = G	Continued from page 9 exited the room. R1 was transferred to ER via ambulance. During an interview on 4/16/26 at 2:30 p.m. NA-A stated she had placed the short black loop on the upper part of the lift bar and the longer dark tan loop on top of the black loop (doubled looped). She had doubled looped the sling loops for security in case the shorter back loop let go. She was informed after the fall that was not the correct way to attach the sling loops to the lift. NA-A stated she had no idea what happened, was unsure if R1 tilted backwards, or how R1 landed on the ground but thought the upper right black short sling loop let loose from the lift. NA-A stated, NA-B may have lifted R1's legs too high when she swung them off the bed and could have possibly caused the fall. She was unsure if R1 slid out or fell from the sling, and how far he fell prior to when he hit the ground. NA-A stated she was taught, unsure where she learned this technique, the lower part of the lift sling was to be placed so that it covered the resident's bottom and top part of the sling was positioned about five inches below the shoulders. This technique was how she placed the sling on R1 prior to when he fell on 4/8/26. The top of the sling was placed down too low. NA-A stated R1's sling was not inspected prior to the fall, inspected after the fall, and no concerns were identified. During an interview on 4/16/26 at 4:08 p.m., family member (FM) stated she was contacted right away after R1 had fallen from the lift and was concerned about the fall. FM stated she had observed staff many times transfer R1 with the lift. FM stated staff always used two assist for transfers, and seemed knowledgeable. A staff member had informed her what they thought had caused the fall from the lift during a visit, one of the loops on the sling was not pulled down and hooked up properly. FM stated staff needed to take the time to double check the sling loops were hooked up properly before they actually pulled R1 up with the lift. During an interview/observation on 4/17/26 at 9:47 a.m., R1's sling was inspected by surveyor with DON present. DON verified it was the same sling used during R1's transfer and fell on 4/8/26. The sling was cream colored with dark tan trim, size medium. The sling appeared intact without tears or rips. DON stated EZ Way sling sizing chart indicated the resident was measured from the neck to the tailbone and the correct sling was identified. R1's sling should have been placed so that the top trim was positioned just above his shoulder and the bottom part of the sling two inches below the tail	F0689		04/17/2026

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F0689 SS = G	Continued from page 10 bone where his bottom met the chair so that R1 did not sit on the sling. DON stated the resident's body should be supported during the lift and transfer. When a sling was placed too high, the resident could have fallen through the sling and if it was placed too low, they could have flipped out the top of the sling. During a follow-up interview on 4/17/26 at 3:00 p.m., DON stated staff were expected to have attached only one loop from the sling to the lift machine on each side (upper and lower) to ensure there was not an error with an incorrect loop being on there. There would be a possibly staff would have not been able to see if the loop underneath remained on lift bar, resulting in both sides looking the same, if not, that may have affected the balance of the sling on the lift. DON stated if the top of the sling was placed on a resident lower than shoulder height, this could potentially cause a fall with a shift in weight of the resident. DON stated the sling and lift machine were inspected after R1's fall on 4/8/26, and everything looked ok. The investigation was completed, and facility was unable to identify what caused R1's fall from the lift but could have resulted from human error. R1's injuries from the fall included a subarachnoid hemorrhage, a tiny amount of bleeding of the frontal lobe and lacerations to the elbow and back of the head. R1 was sent to ER for evaluation, admitted to hospital, monitored/neuro checks, dressings applied to hematoma/lacerations, and administered pain medications. R1 experienced increase in pain due to the fall from the lift with dressing changes. Tramadol was ordered and pain was well controlled. During an interview/observation on 4/17/26 at 10:15 a.m., NA-B brought lift machine and medium sling into room #113 and demonstrated how she transferred R1 on 4/8/26, with the same lift. NA-B stated she was notified via walkie assistance was needed with R1. NA-B entered R1's room to assist NA-A with R1's transfer from shower chair to bed, without incident. Once R1 was placed on the bed, they removed the shower sling, got him dressed, placed a medium lift sling him, lined up the top of sling to the top of his shoulders. The sling loops were crisscrossed between his legs. NA-A moved the lift over the bed. NA-B was unsure if legs of machine were opened or closed. NA-B stood on R1's left side by window, R1's wheelchair was placed to the right side of the window, kiddy corner from the bed. NA-B connected the lower long dark tan loops of the sling on both sides and the upper left side short black loop to the lift. NA-A connected	F0689		04/17/2026

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F0689 SS = G	Continued from page 11 the right top shoulder black short loop to the lift. NA-A lifted R1 up, but not off the bed yet, "We heard a pop sound, most likely a crease in the sling underneath R1 moved or adjusted. NA-B double checked the loops, and all looked ok. NA-A raised R1 up and off bed except for his feet remained on the bed. NA-B walked around to the end of the bed on the left corner, grabbing R1's feet while NA-A pulled the machine backwards away from the bed. R1's feet slid on the mattress until they reached the edge of the bed and supported his feet as they came off the bed. As NA-A pulled lift away from bed the sling rotated so that R1's back faced the machine and his front faced the window. NA-B looked up to see how R1 was doing, made eye contact, then saw him fall out of the top, right side of the sling. NA-B unsure if the right upper short black loop remained hooked onto the lift at time of fall. R1's upper shoulder and head were on the floor and his legs remained in the sling. R1 had Prevalon (puffy boots placed to relieve pressure from heels) boots on both feet, these may have got caught in the sling. NA-B stated NA-A came around the machine and removed the right long sling from the lift and removed the left long sling from the lift. NA-B stated she was unable to remember where the short top black loops were located after the fall, the right upper black loop may have not been on all the way and let go or the sling may not have been wrapped around R1 properly, his weight could have shifted once she had taken his feet off the bed. NA-B saw R1's weight shift, but was unsure if R1 leaned forward, feet sank a bit lower than she had expected, prior to the fall. During the fall, NA-B saw R1 hit his head, saw blood as he laid on the floor, he reached back with his left hand to his head and stated "ouch." R1 made a face, and his face turned red. Staff nurse arrived in room immediately, applied pressure to the back of his head. During this interview, NA-B stood in front of the lift with the sling attached to lift. NA-B positioned the lift at the height from which R1 fell and stated R1 fell approximately 5 feet 6 inches (from top of his head) to the floor on 4/8/26. NA-B pulled herself off the floor for the rest of the shift following the incident. During an interview on 4/17/26 at 12:40 p.m., EZ Way Lift representative (R) stated staff would be expected to position the lift sling on the resident with top part of sling along the shoulders and the bottom part down to the tailbone, not over the hips. Resident should not be sitting on the sling. If the sling was positioned too low on the upper back there could have been a possibility resident fell out of the sling, leaned back and flipped out, or fell out of the right side of the sling. R stated if a sling loop	F0689		04/17/2026

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F0689 SS = G	Continued from page 12 was not attached properly to the lift machine and became unhooked and the sling was not placed up high enough on the body, the resident could have fallen out of the right side of the sling. R stated she was unable to verify if this incident was human error since she was not at the facility. She planned on going to the facility on 6/2/26, to provide education to the staff on EZ lifts. During an interview on 4/17/26 at 1:38 p.m., registered nurse (RN)-C stated staff were expected to place the top of the lift sling over the shoulder bone at the top of the shoulders and the bottom of the sling just below where the tailbone is located. This would be important so that the resident was transported safely via lift. R1 had increased pain after the fall from the lift on 4/8/26, with dressing changes to the elbow and head. Prior to the fall R1 was receiving only Tylenol for pain management. R1 continued to receive Tylenol following the incident, but had tramadol added for pain management. EZ Way Smart Lift Operator's Instructions dated 9/10/26, identified the lift was designed primarily to lift patients from bed, chair, toilet, and floor. Transferring patient from bed to chair, wheelchair, or toilet: Log roll onto side, position sling so that handles on the back of the sling face the mattress. Center the sling under the patient's spine using the center handle as a guide with the base of the sling approximately two inches below the tailbone. At a minimum, top of sling to top of "horseshoe" portion of the sling should run from patient's neckline to at least 2 inches below tailbone Log roll opposite direction and pull rest of sling out the other side. Lay on back and make sure the sling is centered beneath the patient. Lift left thigh, pull the left sling leg of the sling under the patient's thigh and place excess sling over the top of the left thigh, repeat the same steps for the right thigh. Make sure there are no cords or other objects near the path of the lift or near the bed that could obstruct the wheels of the lift. Do no lock wheels of EZ Smart Lift when lifting or transferring patients. Turn hanger bar spreader so the two sling hanger	F0689		04/17/2026

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F0689 SS = G	Continued from page 13 bars are parallel to the patient's body and the sides of the bed. Using the "down" button lower the boom, so it is positioned a few inches over the body of the patient. The goal is to provide for ease of the sling. Attach the loops nearest the patient's shoulders to the hanger bar hooks of the lift nearest each shoulder using the same length and color of loop strap on each side. Take the sling leg lying over the right leg, cross it over and attach it on the hook of the hanger bar located on the left side of the patient using the same length and color of loop strap on each sling. Make a final check of all four loop attachment points to ensure each loop is sufficiently attached to the respective hook of the hanger bars. Patient is now ready to be lifted. Push up button on the hand control to initiate the upward motion of the lift boom. Continue the upward motion until there is tension on the sling legs, making sure all loops on the sling are securely hooked on hanger bars. Lift the patient's knee and smooth out the sling under each of the thighs, if necessary. Continuing lifting the patient so he/she is just high enough to clear the bed. Ensure there are no obstructions on the path of travel. Maneuver the lift away from the bed. During the transfer, do not roll lift over obstructions or into objects that could create imbalance of the lift. Only use the lift operator's handles attached to the mast to maneuver the lift at all times. Do not attempt to move the lift using the boom. Using the spreader bar, adjust the legs of the lift to go around a wheelchair. Position the wheelchair under the patient and lock wheelchair wheels. Using the handles located on the back of the sling, position the patient so that he/she is properly aligned to be lowered onto the wheelchair. Facility policy Safe Resident Handling/Transfers dated 4/2/26, identified it is the policy of this facility to ensure that residents are handled and transferred	F0689		04/17/2026

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F0689 SS = G	Continued from page 14 safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Staff will be educated on the use of safe handling/transfer practices to include use of mechanical lift devices upon hire, and as the need arises or changes in equipment occur. Staff will perform mechanical lifts/transfers according to the manufacturer's instruction for use of the device. Mechanical lift staff training started on 4/8/26 and was provided to the majority of nursing staff prior to the start of their next shift by 4/9/26. Documents reviewed: EZ Way smart lift operator's instructions and Safe Handling policy. A copy of the owner's manual for both lifts and safe handling policy were placed at the nurse's station. EZ Way Lift representative was notified of incident and in person education for staff was scheduled for June 2, 2026.	F0689		04/17/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F0880	EPOC Due:5/17/26 Date Certain: 5/17/26 Ftag: F880 Title of Concern: Infection Prevention and Control Scope and Severity: D Plan of Correction: How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Provide education to all employees regarding enhanced barrier precautions for affected residents. Provide education to all employees regarding the hand hygiene policy and procedure. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.	06/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245597	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/17/2026

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SUNNYSIDE CARE CENTER	16561 US HIGHWAY 10 , LAKE PARK, Minnesota, 56554

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F0880 SS = D	Continued from page 15 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 personal protective equipment (PPE) practices and hand hygiene were performed during a high contact care activity for 1 of 3 residents (R1) in enhanced barrier precautions (EBP) with indwelling devices and open	F0880	Continued from page 15 Audit 100% of residents to ensure enhanced barrier precautions are in place for all residents meeting criteria for enhanced barrier precautions. 3. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. 1. Educate all employees on the policy and procedure of enhanced barrier precautions and hand hygiene. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audit 10% of residents requiring enhanced barrier precautions for proper use by staff weekly x4 weeks, then monthly x2 months. Will have QAPI review the results and make recommendations to continue audits as needed. Corrective action will be monitored by DON or designee. Audit 20 hand hygiene occurrences by staff on various shifts weekly x4 weeks, then monthly x2 months. Will have QAPI review the results and make recommendations to continue audits as needed. Corrective action will be monitored by DON or designee. 5. The date that each deficiency will be corrected: 6/1/26	06/01/2026

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F0880 SS = D	Continued from page 16 wound. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/23/26, identified R1 was admitted to facility on 9/3/25, from a skilled nursing facility. R1 had difficulty communicating some words or finishing thoughts but was able if prompted or given time, and unclear speech. R1 had severely impaired cognition, never/rarely made decisions, and no behaviors. R1 was dependent upon staff for oral/toileting/personal hygiene, dressing, all transfers, used a wheelchair for mobility, and had impaired /functional limitations in range of motion of both upper and lower extremities bilaterally. Diagnoses included: cerebrovascular accident (CVA) (stroke), anemia (low red blood cells), neurogenic bladder, multidrug-resistant organism (MDRO) (a germ such as bacteria, fungi, viruses, and parasites that are resistant to many antibiotics), aphasia (a disorder that affects your ability to speak and understand what others say to you). R1 had feeding tube and indwelling urinary catheter. R1's care plan dated 4/13/26, identified: Enhanced Barrier Precautions (EBP) (infection control interventions designed to reduce transmission of MDROs) and instructed staff to use proper gowning and gloving with high contact care to prevent risk of MDRO transmission. Activities of daily living (ADL) self-care deficit related to hemiplegia (one sided paralysis or weakness) of the right side due to CVA. R1 was dependent upon staff for all cares and transfers. R1 had an inability to drink fluids on his own and had a gastrostomy tube (G-Tube) (a flexible tube placed into the stomach surgically through the abdomen used for administration of fluids and medications). Staff were directed to use EBP with dressing/bathing/showering/transferring/changing linens/providing hygiene, changing brief or assisting with toileting, device care or use of the feeding tube. R1 had a suprapubic catheter (a thin flexible tube that carries urine straight out of bladder through an opening in the lower abdomen and into a collection bag). Staff were instructed to use EBP with high contact resident care. Staff MUST WEAR GLOVES AND GOWN. During an observation on 4/16/26 at 12:57 p.m., physical therapy assistant (PTA) pushed R1 in	F0880		06/01/2026

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F0880 SS = D	Continued from page 17 wheelchair into his room. Nursing assistant (NA)-C followed R1 and PTA into R1's room. There was an EBP sign located on the outside of R1's door and a personal protective equipment (PPE) cart. NA-C and PTA did not apply gown or gloves prior to working with R1. NA-C and PTA transferred R1 from his wheelchair to the bed with use of the full body lift. During an observations on 4/16/26 at 1:05 p.m., NA-D entered R1's room without a gown on. NA-C and NA-D applied gloves, NA-D stood on right side, NA-C stood on left side of R1's bed, rolled him to his left side, pulled down his pants, verified brief was clean, and pulled up brief/pants. R1 was rolled onto his right side and lift sling was removed. Both NAs grabbed ahold of each side of the bed protector located underneath R1 and lifted/boosted him up in the bed, placed pressure relieving boots on both feet, a wedge cushion underneath his left side, pillows between his legs, underneath his lower leg, and under each arm. NA-C and NA-D left the bedside, removed gloves and sanitized their hands before leaving R1's room. During an observation on 4/16/26 at 1:30 p.m., registered nurse (RN)-A entered R1's without gown or gloves on and held a small pill cup. RN-A informed R1 she planned on administering his medications via g-tube. RN-A collected supplies and applied gloves. R1's shirt was raised up to access the g-tube and end of large syringe was attached. RN-A proceeded to administer R1's medicaitons. During an observation on 4/16/26 at 4:45 p.m., RN-B entered R1's room without a gown or gloves on, placed a blue chux on the bedside table, opened Kerlix gauze wrap and a 4 x 4 gauze dressing. She removed the dressing from the back of his head without gloves on and described the wound as 2.5 centimeters (cm) x 3 cm, scant amount of bloody drainage on old dressing, and minimal swelling. The wound site had a dark red scab on it. RN-B did not wash or sanitize her hands, applied clean gloves, applied a folded 4 x 4 gauze dressing, wrapped the Kerlix gauze around his head to secure the dressing, then placed a strip of paper tape to secure the Kerlix gauze, and removed gloves. RN-B cleaned up the garbage and exited room without washing or sanitizing her hands. During an interview on 4/16/26 at 3:00 p.m., NA-D stated staff were expected to wear a gown when a resident was placed in EBP if they planned on changing the brief and/or doing anything below the waistline to prevent the spread of infection to staff, residents and visitors. "According to the E-B-P sign	F0880		06/01/2026

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F0880 SS = D	Continued from page 18 on his [R1's] door, we should have placed a gown on and did not prior to transferring him from the wheelchair to the bed earlier. NA-D stated the only time staff were not required to wear a gown was when answering a call light or administration of a oral medication. R1 had a suprapubic catheter and a feeding tube so required EBP use with close contact cares. During an interview on 4/16/26 at 3:25 p.m., NA-C stated residents in EBP had a sign on their door. Staff would be expected to wear a gown and gloves when cares were completed and when working with bodily fluids. NA-C states it was important to follow EBP requirements to prevent possible spread of infection from one person to another. NA-C stated earlier when she assisted with R1's transfer/cares and should have worn a gown but forgot. During an interview on 4/16/26 at 5:00 p.m., RN-B stated when a resident was placed in EBP staff were expected to wear a gown only while dealing with peri area and/or stoma (a surgical opening in the abdomen used for medical purposes). RN-B read the EBP sign on R1's door and stated the sign was misleading but going forward, yes, technically staff would be expected to wear a gown when working closely with R1 to avoid transmission of germs to be passed onto ourselves and the residents. During an interview on 4/17/26 at 10:57 a.m., RN-A stated when a resident was placed in EBP, staff were expected to use PPE anytime they came in contact with the resident and touched them. RN-A stated she had just figured that out yesterday and realized when R1's medications were administered via g-tube she did not wear PPE. RN-A stated she wore gloves but should have had a gown on to protect R1 and other residents from getting infections and prevent the transfer of germs from one person to another. During an interview on 4/17/26 at 1:38 p.m., RN-C stated staff were expected to wear PPE when a resident was placed in EBP anytime they touched the resident to prevent infection from spreading from one person to another. During an interview on 4/17/26 at 3:00 p.m., director of nursing (DON) stated R1 was admitted to the facility with a previous diagnosis of ESBL, a urinary catheter, g-tube, and placed in EBP. Staff would be expected to wear PPE, a gown and gloves, for tasks that require it (listed on EBP sign posted on door) and during contact with the resident. The use of PPE helped prevent the spread of germs and infection	F0880		06/01/2026

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F0880 SS = D	Continued from page 19 with others. Facility policy EBP dated 4/2/26, identified EBP referred to an infection control intervention designed to reduce transmission of multidrug resistant organisms that employ targeted gown and gloves use during high contact resident care activities. It was the policy of this facility to implement EBP for the prevention of transmission of MDROs. High contact resident care activities include dressing, bathing, transferring, providing hygiene, change linens, change briefs or assisting with toileting, device care: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC (peripherally inserted central catheter) line, midline catheters, and wound care: any skin opening requiring a dressing. EBP sign, undated, Centers for Disease Control and Prevention (CDC) posted on R1's room door identified an orange sign with two red stop signs and written information: EVERYONE MUST: -Clean their hands, including before entering and when leaving the room. -PROVIDERS AND STAFF MUST ALSO: Wear gloves and gown for the following: High Contact Resident Care Activates- Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device (urinary catheter, feeding tube) care or use, wound care: any skin opening requires a dressing.	F0880		06/01/2026

Minnesota Department of Health

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/16/26, and 4/17/26,, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaint was reviewed during the survey H55971168C (2977682). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.	20000		04/17/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		04/17/2026