Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 13, 2025

Administrator
Allina Health Restorative Suites
2775 Campus Drive North
Plymouth, MN 55441

RE: CCN: 245624
Cycle Start Date: August 28, 2025

Dear Administrator:

On November 6, 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3B 3rd Floor
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered

November 13, 2025

Administrator
Allina Health Restorative Suites
2775 Campus Drive North
Plymouth, MN 55441

Re: Reinspection Results
Event ID: 1D5334-H1

Dear Administrator:

On November 6, 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 August 28, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

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September 18, 2025

Administrator
Allina Health Restorative Suites

2775 CAMPUS DRIVE NORTH
PLYMOUTH, MN 55441

RE: CCN:245624
Cycle Start Date: August 28, 2025

Dear Administrator:

On August 28, 2025, a survey was completed at your facility by the Minnesota Departments 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 November 28, 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 February 28, 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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered

September 18, 2025

Administrator
Allina Health Restorative Suites
2775 CAMPUS DRIVE NORTH
PLYMOUTH, MN 55441

Re: State Nursing Home Licensing Orders
Event ID: 1D5334H1

Dear Administrator:

The above facility survey was completed on August 28, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245624	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allina Health Restorative Suites	**2775 CAMPUS DRIVE NORTH , PLYMOUTH, Minnesota, 55441**

(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 8/26/25, 8/27/25, & 8/28/25, 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: H56242541C (2592433), with deficiencies cited at F657 & 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		09/18/2025
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F0657	F0657 It is the policy of Cassia (Allina Health Restorative Suites) to comply with 42 CFR §483.21(b)(1)-(3), which requires the facility to develop and implement a comprehensive, person-centered care plan for each resident that includes measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs, including the level of supervision required to prevent falls. To assure continued compliance, the following plan has been put into place: The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: The comprehensive care plans for residents R2 is no	10/15/2025

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: 245624	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

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F0657 SS = D	Continued from page 1 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to revise the comprehensive care plan to include individualized person-centered interventions identifying the needed level of supervision to negate the risk of falls for 2 of 3 residents (R2, R3) reviewed for falls. Findings include: R2 R2's minimum data set (MDS) assessment dated 8/14/25, indicated she admitted to the facility on 8/8/25 with diagnoses including displaced simple supracondylar fracture without intercondylar fracture of the right humerus (broken bone in the lower part of the upper arm), other fracture, history of falling, and other disorder of bone density and structure. R2 had mild cognitive impairment. R2 had fallen in the last month prior to admission, had a fracture related to a fall in the six months prior to admission, and had one fall with a non-major injury since admission to the facility. R2's Nursing Admission Assessment dated 8/8/25, included a John's Hopkins Fall Risk Assessment. R2 was identified as at high risk for falls with score of 14. R2's care plan focus dated 8/8/25, identified she was at risk for falls with history of falls. Intervention dated 8/8/25, included physical therapy and occupational therapy to evaluate and treat as needed. Interventions dated 8/9/25 included: Ensure I am wearing appropriate footwear; If a fall should occur, take vital signs and assess for injury. Document	F0657	Continued from page 1 longer a current resident. R3's comprehensive care plan were immediately reviewed and revised to include individualized, person-centered interventions specifying the required level of supervision to mitigate fall risk. Actions taken to identify other potential residents having similar occurrences: Current residents with a history of falls or identified as at risk for falls had their care plans reviewed to ensure individualized interventions and supervision levels are clearly documented. Measures put in place to ensure deficient practice does not recur: Interdisciplinary team members received education on the requirement to include individualized, person-centered interventions in care plans for residents at risk for falls. Effective implementation of actions will be monitored by: The facility will audit random sample of 5 resident care plans for residents at risk for falls weekly for one month to ensure individualized interventions and supervision levels are documented as required. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. The person responsible to maintain compliance is: Director of Nursing and/or Designee Completion date: 10/15/25	

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F0657 SS = D	Continued from page 2 circumstances and possible causes of fall. Notify family and physician of all falls; Monitor for side effects of medications and update provider as indicated; Observe for restlessness. If restless, attempt to determine cause of restlessness (such as pain or toileting need) and meet that need as able. R2's progress note dated 8/14/25, indicated R2 fell. A nurse saw R2 on the floor next to her recliner with knees on the floor and clinical coordinator assisting her. She had a left elbow skin tear. Her call light was not on, it was clipped to the blanket covering her, but she did not use it before getting up. R2 was assisted to the bathroom and had a large bowel movement. Interventions were to offer toileting every two hours and as needed, remind to use call light and not transfer without assistance, keep call light in reach at all times, staff to anticipate needs, and frequent checks, door stays open. The progress note did not identify what frequent checks meant or the corresponding needed level of supervision to mitigate the risk of falls. R2's progress note dated 8/15/25, identified it was inter-disciplinary team (IDT) fall follow up. R2 had fallen attempting to get herself to the bathroom and due to cognitive deficit did not use her call light which had been clipped to her blanket. Staff were to anticipate her need for use of toilet, a toileting plan was initiated, and frequent checks and door open when appropriate. Care plan and care strip [a paper summary of care plans used by nursing assistants] were updated with interventions. The progress note did not identify what frequent checks meant or the corresponding needed level of supervision to mitigate the risk of falls. R2's fall care plan intervention dated 8/15/25, directed see skin care plan for toileting plan. Staff to anticipate needs for toileting. Revision dated 8/18/25, changed this intervention to pharmacist medication review. Interventions dated 8/17/25, included see bowel and bladder care plan for my toileting schedule and "frequent checks," keep door open when appropriate. R2's fall care plan did not identify what constituted frequent checks and failed to identify what R2's specific individualized needed level of supervision was to mitigate the risk of falls. R2's progress note dated 8/18/25, indicated it was an IDT review of the fall on 8/14/25. Root cause identified was poor cognition, possible urgency feeling need to have a bowel movement and had received a dose of a laxative on 8/14/25. Initial interventions were initiation of a toileting plan as well as frequent	F0657		

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F0657 SS = D	Continued from page 3 checks and door open when appropriate. The IDT interventions were pharmacist medication review and offer toileting every two to three hours and as needed. R2's care strip dated 8/27/25, identified she was a fall risk. The General Notes section included, "Fall risk – frequent checks & door open, anticipate needs for toileting." The care strip did not identify what constituted frequent checks and failed to identify what R2's specific individualized needed level of supervision was to mitigate the risk of falls. During an interview on 8/27/25 at 8:36 a.m., nursing assistant (NA)-A stated R2 was a little confused and sometimes used her call light when she needed to toilet, but it depended on the day. NA-A stated staff checked on R2 every one to two hours and she was toileted every two hours. NA-A stated frequent checks meant someone was a fall risk, staff needed to check on them to prevent falls, and checks were done every one to two hours. During an interview on 8/27/25 at 10:02 a.m., NA-B stated care strips were a version of the care plan and directed staff what cares a resident needed. Care strips told staff how often someone needed checks and if they were a fall risk. Frequent checks meant checking on someone more than usual, like rounding every 15 minutes if they fell frequently or were known to not use a call light. NA-B stated R2 was a fall risk, didn't always use the call light, and was to be checked on every two hours. NA-B did not articulate awareness R2 was on frequent checks as a fall intervention or identify R2 required an increased level of supervision beyond standard two-hour checks. During an interview on 8/27/25 at 10:25 a.m., registered nurse (RN)-B stated fall risk and interventions were identified in the electronic health record (EHR) and on care strips. Interventions for falls included frequent checks which were "like protocol." Frequent checks should be done every 30 minutes. RN-B stated R2 was a fall risk but was not aware R2 had fallen while at the facility. RN-B stated fall interventions for R2 included call light, grippy socks, and frequent checks specifically because she was forgetful. As a nurse, RN-B checked on R2 every 30 minutes and the NAs checked on her every hour. R3 R3's MDS assessment dated 8/19/25, indicated she admitted to the facility on 8/13/25 with diagnoses	F0657		

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F0657 SS = D	Continued from page 4 including Alzheimer's disease, non-Alzheimer's dementia, sepsis, and enterocolitis (inflammation of the large and small intestines) due to Clostridium difficile (C. diff, a bacterium that causes severe diarrhea and colon inflammation). R2 had severely impaired cognition and had one fall without injury since admission to the facility. R3's Nursing Admission Assessment dated 8/13/25, included a John's Hopkins Fall Risk Assessment. R3 was identified as at high risk for falls with score of 14. R3's care plan focus dated 8/13/25, identified she was at risk for falls. Interventions included physical therapy and occupational therapy to evaluate and treat as needed. R3's progress note dated 8/15/25, indicated R3 fell, and a nurse found her lying on the floor on her back with head facing recliner. R3 stated she flew out of the chair and did not remember why she fell or what she was trying to do. She appeared confused, which was her baseline. She was to have every hour checks, offer toileting, water, repositioning. She did not appear to understand use of the call light. Staff spoke to her spouse who stated caregivers from home would come and stay with her for a few hours in the evening. R3's fall care plan intervention dated 8/15/25, identified family or home caregivers offering to stay with guest as needed. R3's progress note dated 8/16/25, indicated it was an IDT review of the fall on 8/15/25. Root cause was C. Diff, urgency need combined with poor cognitive abilities related to Alzheimer's. Initial interventions were hourly checks with offering toileting, water, and repositioning, and family came to sit with R3. IDT interventions were to discontinue the initial intervention of hourly checks and bed in lowest position. IDT initiated a check and change program every two to three hours and as needed and updated the pharmacist to complete a medication review. R3's fall care plan intervention dated 8/17/25, was pharmacist medication review. Intervention dated 8/18/25, was to see bowel and bladder care plan for toileting schedule. Additional intervention dated 8/18/25, directed staff to complete "frequent checks," if resident alone keep door to room open. R3's fall care plan did not identify what constituted frequent checks and failed to identify what R3's specific individualized needed level of supervision was to mitigate the risk of falls.	F0657		

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Allina Health Restorative Suites	2775 CAMPUS DRIVE NORTH , PLYMOUTH, Minnesota, 55441

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F0657 SS = D	Continued from page 5 R3's progress note dated 8/20/25, indicated an aide found R3 lying on the floor in her room on her side with head facing the recliner. R3 stated she "flew slide down of the chair," did not remember why she fell or what she was trying to do, and complained of dizziness. R3 was to have every hour checks and offer toileting, water, repositioning and did not understand using the call light. R3's physician order dated 8/20/25, directed staff to complete frequent checks throughout shift. Observe for incontinent episodes of bowel movement and address as soon as possible. Document frequency every shift, amount, consistency of bowel movements and any other pertinent information. R3's progress note dated 8/21/25, identified it was IDT review of the fall on 8/20/25. R3 had complained of getting a little dizzy, was confused and unable to recall what she was trying to do, was having frequent loose stools. Labs were monitored with low potassium last week which improved on 8/19/25. Root cause included possible electrolyte imbalance or result of infection's impact on physiology and mental status. Dizziness may be related to a drop in blood pressure with position change. New interventions were provider ordered labs with IDT intervention of check orthostatic blood pressure and therapy notified to check during therapy sessions. R3's fall care plan interventions dated 8/21/25, included check orthostatic blood pressure as needed for falls/syncope/dizziness, and lab work ordered due to infection and continued loose stools related to C. diff and vaginal fistula. R3's care strip dated 8/27/25, identified she was a fall risk. The General Notes section included, "Frequent checks. Door open when alone in room." The care strip did not identify what constituted frequent checks and failed to identify what R3's specific individualized needed level of supervision was to mitigate the risk of falls. During an interview on 8/27/25 at 10:02 a.m., NA-B stated R3 was a fall risk, had a caregiver from home present during the day. If the caregiver wasn't present, staff had to check on her at least every hour because she didn't use her call light due to cognition. NA-B stated R3 was just on routine checks, then looked at R3's care strip, and stated it directed R3 was on frequent checks, keep door open when alone in room. When asked how often R3's frequent checks were to be	F0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245624	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0657 SS = D	Continued from page 6 done, NA-B stated she didn't know, the paper didn't say, it just said "frequent," so staff needed to check on her more often than every two hours. NA-B would say checks should be done every 45 minutes to one hour and then stated that checks needed to be completed even if a resident had a visitor with them. During an interview on 8/27/25 at 12:11 p.m., NA-C stated fall risk was identified on care plans and care sheets [strips]. For residents at risk of falls, staff checked on them every hour. NA-C was unable to articulate where a resident's specific needed level of supervision would be identified, it was just the standard to check on them every hour. Frequent checks were for residents at risk of falls and did not mean any specific time, but he would say checks should be every 30 minutes. During an interview on 8/27/25 at 1:18 p.m., NA-D stated frequent checks on a care plan or care strip meant staff needed to go into the room and check on residents. The frequency depended on a resident's care plan, the care strip would specify such as 15-minute checks or two-hour checks. If it only stated frequent with no specified parameter, he would do checks at a minimum of every 15 minutes. Frequent checks were to look at a resident's safety and were used for falls. During an interview on 8/27/25 at 12:38 p.m., RN-D stated interventions for someone at risk for falls were on care plans and the care strips. Frequent checks could be a fall intervention and meant checking on the resident every 15 to 20 minutes. A resident's needed level of supervision was determined by the admission nurse and clinical coordinator who put it on the care plan. During an interview on 8/28/25 at 9:43 a.m., clinical manager (CM)-A stated she was "not a fan" of the term "frequent" checks and it was not a word she used. Frequent checks was an opinion and represented a wide range, though she would say frequent meant at least hourly. If a care plan for falls identified frequent checks as an intervention, she expected her staff not to use that word and to put a resident on specific checks such as hourly. Needed level of supervision for residents at risk for falls was determined by nurses and managers and should be specific such as every hour or every two hours. CM-A expected care plans and interventions to be individualized and person-centered. CM-A stated frequent checks were not an individualized person-centered fall intervention. During an interview on 8/28/25 at 11:00 a.m., CM-B	F0657		

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F0657 SS = D	Continued from page 7 stated as an intervention, frequent checks alerted staff someone was a fall risk. It meant go in and check on the resident and be aware if the resident was in their room and a fall risk. Frequent checks were having more eyes on the resident room, nurse checks, and staff checking when near the room. He did not set times for the frequency of checks. CM-B was unable to articulate how a staff member unfamiliar with a resident, such as a new hire or agency employee, would be expected to identify a resident's specific needed level of supervision based on an intervention of frequent checks. They should interpret it as the resident needed extra attention and two-to-three-hour checks were within reason. The specific level of supervision a person needed to mitigate the risk of falls was an increased level of monitoring above the usual. CM-B confirmed frequent checks did not specify the needed level of supervision or monitoring for a resident and did not identify the frequency with which checks were to be completed. Appropriate levels of supervision were determined after a fall through IDT discussion and root cause analysis to make an intervention. CM-B expected care plans and interventions to be person centered and individualized. During an interview on 8/28/25 at 11:25 a.m., the director of nursing (DON) stated she did not like the term frequent checks because frequent checks are "vague" and staff "don't know what it means." The DON stated she had instructed staff not to use it as an intervention because it was "not appropriate" and meant one thing to one person and something different to another. She expected care plans to identify the level of supervision a resident needed to mitigate the risk of falls with a personalized and specific intervention. She expected care plans to be revised to include individual residents' needs. She confirmed frequent checks did not reflect a resident's specific needed level of supervision and was not person-centered or individualized. Facility policy titled Fall Assessment and Managing Fall Risk dated 11/6/23, identified fall risk and appropriate interventions to minimize risk of falls and/or risk of injury from falls were included in the care plan. After a fall and based on review of the fall, interventions in the care plan were updated as indicated. Falls were reviewed by the IDT for appropriate interventions and the IDT made recommendations/changes as need to the plan of care, and profile or NA assignment sheet. Staff nurses were responsible to make safety rounds throughout their shift to ensure compliance with required safety devices as indicated on the residents' plan of care.	F0657		

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F0657 SS = D	Continued from page 8 Facility policy titled Care Plan and Baseline Care Plan dated 10/14/22, identified the interdisciplinary team, in conjunction with the resident, resident's family, significant other or resident representative, should develop a comprehensive person-centered care plan for each resident. The resident care plan was constantly changing as was to be updated routinely in the electronic record to reflect a resident's current condition. Care plans were updated with MDS/care conference schedule and as needed to assure that they were an accurate reflection of the resident and their care needs. The comprehensive care plan included the care plan and physician orders.	F0657		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F0880	F0880 It is the policy of Cassia to comply with 42 CFR §483.80 Infection Control, which requires the facility to 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. To assure continued compliance, the following plan has been put into place: The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: The staff member involved was immediately re-educated on proper hand hygiene and observed performing correct handwashing before providing further care to resident R3. Actions taken to identify other potential residents having similar occurrences: Current residents have been reviewed to ensure no acute infections have occurred related to potential breeches in infection control practices. Measures put in place to ensure deficient practice does not recur: Staff will receive in-service education on infection	10/15/2025

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F0880 SS = D	Continued from page 9 (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 record review, the facility failed to ensure staff followed infection control protocols for proper handwashing for 1 of 1 resident (R3) reviewed on contact precautions. Findings include: R3's minimum data set (MDS) assessment dated 8/19/25, indicated she admitted to the facility on 8/13/25 with diagnoses including enterocolitis (inflammation of the	F0880	Continued from page 9 control protocols, specifically focusing on hand hygiene and contact precautions. Effective implementation of actions will be monitored by: The Infection Preventionist and/or Designee will audit random sample of 3 staff-resident care episodes a day for 2 week, then decrease to 1 random staff- resident care episode a day for 2 weeks to ensure proper hand hygiene is performed. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. The person responsible to maintain compliance is: Director of Nursing and/or designee Completion date: 10/15/25	

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F0880 SS = D	Continued from page 10 large and small intestines) due to Clostridium difficile (C. diff, a bacterium that causes severe diarrhea and colon inflammation) and was always incontinent of bowel. R3's physician order dated 8/14/25, identified she was on contact enteric isolation precautions (measures taken to prevent the transmission of infectious agents including C. diff which include the use of personal protective equipment and hand hygiene). The order directed staff to gown and glove upon room entry, hand hygiene with soap and water, bleach sanitizing wipes, all meals and services in room every shift. R3's care plan focus dated 8/13/25, identified R3 had an infection with C. diff. Interventions included follow contact enteric precautions when caring for R3. During a continuous observation on 8/27/25 at 9:00 a.m., R3's room had a container with personal protective equipment (PPE) outside the door and a sign on the door. The sign directed, "Contact enteric precautions (in addition to standard precautions) … Everyone must: Clean hands with sanitizer when entering room and wash with soap and water upon leaving the room. Doctors and staff must: Gown and glove at door. Use dedicated or disposable equipment. Clean and disinfect shared equipment." At 9:25 a.m., registered nurse (RN)-A approached R3's room, utilized hand sanitizer, donned (put on) a gown and gloves, and entered the room. At 9:26 a.m., RN-A exited R3's room with gown and gloves removed and was observed rubbing his hands together with a foamy substance present. RN-A then walked down the hall to a medication cart. During an interview on 8/27/25 at 9:27 a.m., RN-A stated he saw a sign on R3's door for enteric contact precautions. RN-A identified this meant when entering, he had to clean his hands and put on a gown and gloves. When exiting, there was "foam sanitizer" right by the door inside the room and he would "use that." RN-A stated he utilized the hand sanitizer in the room after removal of gown and gloves. RN-A identified the precautions sign on R3's door directed staff to wash hands with soap and water when leaving the room and there was a sink down the hall where staff could wash their hands. RN-A confirmed he utilized hand sanitizer when he exited R3's room, did not wash his hands with soap and water, and had subsequently gone to and touched the medication cart. RN-A stated for enteric precautions, like someone with C. diff, hand hygiene with soap and water was needed to prevent spreading infection and transmitting C. diff to another resident or even himself.	F0880		

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F0880 SS = D	Continued from page 11 During an interview on 8/27/25 at 9:46 a.m., the director of nursing (DON) stated when staff exit a room with contact enteric precautions, they need to remove their PPE and “then wash their hands.” She expected staff to go out of the room and straight to an area to wash their hands. Anything touched along the way before washing hands would need to be sanitized. The DON noted it was not okay to touch the medication cart before washing hands. With C. diff, soap and water was the standard for hand hygiene. The risk of not using soap and water for hand hygiene was the potential to spread C. diff bacteria. During an interview on 8/28/25 at 10:22 a.m., the facility’s infection preventionist (IP) stated she expected staff exiting a room of a resident with C. diff to wash their hands with soap and water. The IP noted this is what she trained staff to do, what the contact enteric precaution door signs directed, and what facility policy indicated. Hand sanitizer was not effective against C. diff. The risk of not washing hands with soap and water was still having some of the contagious organism present on hands or skin, touching other surfaces or people, and spreading it to other people or oneself. Facility policy titled Infection Control dated 5/13/25, identified transmission based precautions were used in addition to standard precautions for diseases with multiple routes of transmission, including contact precautions. Contact or touch was the most common and significant mode of transmission of infectious agents and residents in contact precautions included those infected with C. diff. Facility policy titled Clostridium Difficile Infection dated 4/3/24, identified C. diff was a spore-forming bacteria found in feces and health care workers could spread the bacteria to other residents or contaminate surfaces through hand contact. Residents would be placed on contact or enhanced barrier precautions. Enhanced barrier precautions were only to be used if the resident was continent of bowel or the diarrhea could be contained in an incontinence product. Residents with acute diarrhea would be in contact precautions. A contact or enhanced barrier precautions sign was to be placed on the resident’s door. Gloves would be worn prior to entering the room and removed before exiting with hand hygiene performed before putting on gloves, after removing gloves, and any time hands were visibly soiled.	F0880		

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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 8/26/25, 8/27/25, & 8/28/25, 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		09/18/2025

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

Minnesota State Department of Health

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20000	Continued from page 1 The following complaint was reviewed: H56242541C (2592433) with licensing orders issued at 0570 & 1375. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the	20570	Corrected.	10/15/2025

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20570	Continued from page 2 resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to revise the comprehensive care plan to include individualized person-centered interventions identifying the needed level of supervision to negate the risk of falls for 2 of 3 residents (R2, R3) reviewed for falls. Findings include: R2's minimum data set (MDS) assessment dated 8/14/25, indicated she admitted to the facility on 8/8/25 with diagnoses including displaced simple supracondylar fracture without intercondylar fracture of the right humerus (broken bone in the lower part of the upper arm), other fracture, history of falling, and other disorder of bone density and structure. R2 had mild cognitive impairment. R2 had fallen in the last month prior to admission, had a fracture related to a fall in the six months prior to admission, and had one fall with a non-major injury since admission to the facility. R2's Nursing Admission Assessment dated 8/8/25, included a John's Hopkins Fall Risk Assessment. R2 was identified as at high risk for falls with score of 14. R2's care plan focus dated 8/8/25, identified she was at risk for falls with history of falls. Intervention dated 8/8/25, included physical therapy and occupational therapy to evaluate and treat as needed. Interventions dated 8/9/25 included: Ensure I am wearing appropriate footwear; If a fall should occur, take vital signs and assess for injury. Document circumstances and possible causes of fall. Notify family and physician of all falls; Monitor for side effects of medications and update provider as indicated; Observe for restlessness. If restless, attempt to determine cause of restlessness (such as pain or toileting need) and meet that need as able. R2's progress note dated 8/14/25, indicated R2 fell. A nurse saw R2 on the floor next to her recliner with knees on the floor and clinical coordinator assisting her. She had a left elbow skin tear. Her call light was not on, it was clipped to the blanket covering her, but	20570		

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20570	Continued from page 3 she did not use it before getting up. R2 was assisted to the bathroom and had a large bowel movement. Interventions were to offer toileting every two hours and as needed, remind to use call light and not transfer without assistance, keep call light in reach at all times, staff to anticipate needs, and frequent checks, door stays open. The progress note did not identify what frequent checks meant or the corresponding needed level of supervision to mitigate the risk of falls. R2's progress note dated 8/15/25, identified it was inter-disciplinary team (IDT) fall follow up. R2 had fallen attempting to get herself to the bathroom and due to cognitive deficit did not use her call light which had been clipped to her blanket. Staff were to anticipate her need for use of toilet, a toileting plan was initiated, and frequent checks and door open when appropriate. Care plan and care strip [a paper summary of care plans used by nursing assistants] were updated with interventions. The progress note did not identify what frequent checks meant or the corresponding needed level of supervision to mitigate the risk of falls. R2's fall care plan intervention dated 8/15/25, directed see skin care plan for toileting plan. Staff to anticipate needs for toileting. Revision dated 8/18/25, changed this intervention to pharmacist medication review. Interventions dated 8/17/25, included see bowel and bladder care plan for my toileting schedule and "frequent checks," keep door open when appropriate. R2's fall care plan did not identify what constituted frequent checks and failed to identify what R2's specific individualized needed level of supervision was to mitigate the risk of falls. R2's progress note dated 8/18/25, indicated it was an IDT review of the fall on 8/14/25. Root cause identified was poor cognition, possible urgency feeling need to have a bowel movement and had received a dose of a laxative on 8/14/25. Initial interventions were initiation of a toileting plan as well as frequent checks and door open when appropriate. The IDT interventions were pharmacist medication review and offer toileting every two to three hours and as needed. R2's care strip dated 8/27/25, identified she was a fall risk. The General Notes section included, "Fall risk – frequent checks & door open, anticipate needs for toileting." The care strip did not identify what constituted frequent checks and failed to identify what R2's specific individualized needed level of supervision was to mitigate the risk of falls.	20570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/28/2025**

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20570	Continued from page 4 During an interview on 8/27/25 at 8:36 a.m., nursing assistant (NA)-A stated R2 was a little confused and sometimes used her call light when she needed to toilet, but it depended on the day. NA-A stated staff checked on R2 every one to two hours and she was toileted every two hours. NA-A stated frequent checks meant someone was a fall risk, staff needed to check on them to prevent falls, and checks were done every one to two hours. During an interview on 8/27/25 at 10:02 a.m., NA-B stated care strips were a version of the care plan and directed staff what cares a resident needed. Care strips told staff how often someone needed checks and if they were a fall risk. Frequent checks meant checking on someone more than usual, like rounding every 15 minutes if they fell frequently or were known to not use a call light. NA-B stated R2 was a fall risk, didn't always use the call light, and was to be checked on every two hours. NA-B did not articulate awareness R2 was on frequent checks as a fall intervention or identify R2 required an increased level of supervision beyond standard two-hour checks. During an interview on 8/27/25 at 10:25 a.m., registered nurse (RN)-B stated fall risk and interventions were identified in the electronic health record (EHR) and on care strips. Interventions for falls included frequent checks which were "like protocol." Frequent checks should be done every 30 minutes. RN-B stated R2 was a fall risk but was not aware R2 had fallen while at the facility. RN-B stated fall interventions for R2 included call light, grippy socks, and frequent checks specifically because she was forgetful. As a nurse, RN-B checked on R2 every 30 minutes and the NAs checked on her every hour. R3 R3's MDS assessment dated 8/19/25, indicated she admitted to the facility on 8/13/25 with diagnoses including Alzheimer's disease, non-Alzheimer's dementia, sepsis, and enterocolitis (inflammation of the large and small intestines) due to Clostridium difficile (C. diff, a bacterium that causes severe diarrhea and colon inflammation). R2 had severely impaired cognition and had one fall without injury since admission to the facility. R3's Nursing Admission Assessment dated 8/13/25, included a John's Hopkins Fall Risk Assessment. R3 was identified as at high risk for falls with score of 14.	20570		

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20570	Continued from page 5 R3's care plan focus dated 8/13/25, identified she was at risk for falls. Interventions included physical therapy and occupational therapy to evaluate and treat as needed. R3's progress note dated 8/15/25, indicated R3 fell, and a nurse found her lying on the floor on her back with head facing recliner. R3 stated she flew out of the chair and did not remember why she fell or what she was trying to do. She appeared confused, which was her baseline. She was to have every hour checks, offer toileting, water, repositioning. She did not appear to understand use of the call light. Staff spoke to her spouse who stated caregivers from home would come and stay with her for a few hours in the evening. R3's fall care plan intervention dated 8/15/25, identified family or home caregivers offering to stay with guest as needed. R3's progress note dated 8/16/25, indicated it was an IDT review of the fall on 8/15/25. Root cause was C. Diff, urgency need combined with poor cognitive abilities related to Alzheimer's. Initial interventions were hourly checks with offering toileting, water, and repositioning, and family came to sit with R3. IDT interventions were to discontinue the initial intervention of hourly checks and bed in lowest position. IDT initiated a check and change program every two to three hours and as needed and updated the pharmacist to complete a medication review. R3's fall care plan intervention dated 8/17/25, was pharmacist medication review. Intervention dated 8/18/25, was to see bowel and bladder care plan for toileting schedule. Additional intervention dated 8/18/25, directed staff to complete "frequent checks," if resident alone keep door to room open. R3's fall care plan did not identify what constituted frequent checks and failed to identify what R3's specific individualized needed level of supervision was to mitigate the risk of falls. R3's progress note dated 8/20/25, indicated an aide found R3 lying on the floor in her room on her side with head facing the recliner. R3 stated she "flew slide down of the chair," did not remember why she fell or what she was trying to do, and complained of dizziness. R3 was to have every hour checks and offer toileting, water, repositioning and did not understand using the call light. R3's physician order dated 8/20/25, directed staff to complete frequent checks throughout shift. Observe for	20570		

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20570	Continued from page 6 incontinent episodes of bowel movement and address as soon as possible. Document frequency every shift, amount, consistency of bowel movements and any other pertinent information. R3's progress note dated 8/21/25, identified it was IDT review of the fall on 8/20/25. R3 had complained of getting a little dizzy, was confused and unable to recall what she was trying to do, was having frequent loose stools. Labs were monitored with low potassium last week which improved on 8/19/25. Root cause included possible electrolyte imbalance or result of infection's impact on physiology and mental status. Dizziness may be related to a drop in blood pressure with position change. New interventions were provider ordered labs with IDT intervention of check orthostatic blood pressure and therapy notified to check during therapy sessions. R3's fall care plan interventions dated 8/21/25, included check orthostatic blood pressure as needed for falls/syncope/dizziness, and lab work ordered due to infection and continued loose stools related to C. diff and vaginal fistula. R3's care strip dated 8/27/25, identified she was a fall risk. The General Notes section included, "Frequent checks. Door open when alone in room." The care strip did not identify what constituted frequent checks and failed to identify what R3's specific individualized needed level of supervision was to mitigate the risk of falls. During an interview on 8/27/25 at 10:02 a.m., NA-B stated R3 was a fall risk, had a caregiver from home present during the day. If the caregiver wasn't present, staff had to check on her at least every hour because she didn't use her call light due to cognition. NA-B stated R3 was just on routine checks, then looked at R3's care strip, and stated it directed R3 was on frequent checks, keep door open when alone in room. When asked how often R3's frequent checks were to be done, NA-B stated she didn't know, the paper didn't say, it just said "frequent," so staff needed to check on her more often than every two hours. NA-B would say checks should be done every 45 minutes to one hour and then stated that checks needed to be completed even if a resident had a visitor with them. During an interview on 8/27/25 at 12:11 p.m., NA-C stated fall risk was identified on care plans and care sheets [strips]. For residents at risk of falls, staff checked on them every hour. NA-C was unable to articulate where a resident's specific needed level of	20570		

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20570	Continued from page 7 supervision would be identified, it was just the standard to check on them every hour. Frequent checks were for residents at risk of falls and did not mean any specific time, but he would say checks should be every 30 minutes. During an interview on 8/27/25 at 1:18 p.m., NA-D stated frequent checks on a care plan or care strip meant staff needed to go into the room and check on residents. The frequency depended on a resident's care plan, the care strip would specify such as 15-minute checks or two-hour checks. If it only stated frequent with no specified parameter, he would do checks at a minimum of every 15 minutes. Frequent checks were to look at a resident's safety and were used for falls. During an interview on 8/27/25 at 12:38 p.m., RN-D stated interventions for someone at risk for falls were on care plans and the care strips. Frequent checks could be a fall intervention and meant checking on the resident every 15 to 20 minutes. A resident's needed level of supervision was determined by the admission nurse and clinical coordinator who put it on the care plan. During an interview on 8/28/25 at 9:43 a.m., clinical manager (CM)-A stated she was "not a fan" of the term "frequent" checks and it was not a word she used. Frequent checks was an opinion and represented a wide range, though she would say frequent meant at least hourly. If a care plan for falls identified frequent checks as an intervention, she expected her staff not to use that word and to put a resident on specific checks such as hourly. Needed level of supervision for residents at risk for falls was determined by nurses and managers and should be specific such as every hour or every two hours. CM-A expected care plans and interventions to be individualized and person-centered. CM-A stated frequent checks were not an individualized person-centered fall intervention. During an interview on 8/28/25 at 11:00 a.m., CM-B stated as an intervention, frequent checks alerted staff someone was a fall risk. It meant go in and check on the resident and be aware if the resident was in their room and a fall risk. Frequent checks were having more eyes on the resident room, nurse checks, and staff checking when near the room. He did not set times for the frequency of checks. CM-B was unable to articulate how a staff member unfamiliar with a resident, such as a new hire or agency employee, would be expected to identify a resident's specific needed level of supervision based on an intervention of frequent checks. They should interpret it as the resident needed	20570		

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20570	Continued from page 8 extra attention and two-to-three-hour checks were within reason. The specific level of supervision a person needed to mitigate the risk of falls was an increased level of monitoring above the usual. CM-B confirmed frequent checks did not specify the needed level of supervision or monitoring for a resident and did not identify the frequency with which checks were to be completed. Appropriate levels of supervision were determined after a fall through IDT discussion and root cause analysis to make an intervention. CM-B expected care plans and interventions to be person centered and individualized. During an interview on 8/28/25 at 11:25 a.m., the director of nursing (DON) stated she did not like the term frequent checks because frequent checks are “vague” and staff “don’t know what it means.” The DON stated she had instructed staff not to use it as an intervention because it was “not appropriate” and meant one thing to one person and something different to another. She expected care plans to identify the level of supervision a resident needed to mitigate the risk of falls with a personalized and specific intervention. She expected care plans to be revised to include individual residents’ needs. She confirmed frequent checks did not reflect a resident’s specific needed level of supervision and was not person-centered or individualized. Facility policy titled Fall Assessment and Managing Fall Risk dated 11/6/23, identified fall risk and appropriate interventions to minimize risk of falls and/or risk of injury from falls were included in the care plan. After a fall and based on review of the fall, interventions in the care plan were updated as indicated. Falls were reviewed by the IDT for appropriate interventions and the IDT made recommendations/changes as need to the plan of care, and profile or NA assignment sheet. Staff nurses were responsible to make safety rounds throughout their shift to ensure compliance with required safety devices as indicated on the residents’ plan of care. Facility policy titled Care Plan and Baseline Care Plan dated 10/14/22, identified the interdisciplinary team, in conjunction with the resident, resident’s family, significant other or resident representative, should develop a comprehensive person-centered care plan for each resident. The resident care plan was constantly changing as was to be updated routinely in the electronic record to reflect a resident’s current condition. Care plans were updated with MDS/care conference schedule and as needed to assure that they were an accurate reflection of the resident and their	20570		

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20570	Continued from page 9 care needs. The comprehensive care plan included the care plan and physician orders. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review/revise policies and procedures on fall prevention and care plan revision. The administrator, DON, or designee could educate all staff on these policies and procedures. The administrator, DON, or designee could audit to ensure all resident care plans are up-to-date and revised to include person-centered individualized interventions, all staff members are aware of these interventions and needed levels of supervision to mitigate fall risk, and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20570		
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff followed infection control protocols for proper handwashing for 1 of 1 resident (R3) reviewed on contact precautions. Findings include Findings include: R3's minimum data set (MDS) assessment dated 8/19/25, indicated she admitted to the facility on 8/13/25 with diagnoses including enterocolitis (inflammation of the large and small intestines) due to Clostridium difficile (C. diff, a bacterium that causes severe diarrhea and colon inflammation) and was always incontinent of bowel. R3's physician order dated 8/14/25, identified she was on contact enteric isolation precautions (measures taken to prevent the transmission of infectious agents	21375	Corrected.	10/15/2025

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21375	Continued from page 10 including C. diff which include the use of personal protective equipment and hand hygiene). The order directed staff to gown and glove upon room entry, hand hygiene with soap and water, bleach sanitizing wipes, all meals and services in room every shift. R3's care plan focus dated 8/13/25, identified R3 had an infection with C. diff. Interventions included follow contact enteric precautions when caring for R3. During a continuous observation on 8/27/25 at 9:00 a.m., R3's room had a container with personal protective equipment (PPE) outside the door and a sign on the door. The sign directed, "Contact enteric precautions (in addition to standard precautions) … Everyone must: Clean hands with sanitizer when entering room and wash with soap and water upon leaving the room. Doctors and staff must: Gown and glove at door. Use dedicated or disposable equipment. Clean and disinfect shared equipment." At 9:25 a.m., registered nurse (RN)-A approached R3's room, utilized hand sanitizer, donned (put on) a gown and gloves, and entered the room. At 9:26 a.m., RN-A exited R3's room with gown and gloves removed and was observed rubbing his hands together with a foamy substance present. RN-A then walked down the hall to a medication cart. During an interview on 8/27/25 at 9:27 a.m., RN-A stated he saw a sign on R3's door for enteric contact precautions. RN-A identified this meant when entering, he had to clean his hands and put on a gown and gloves. When exiting, there was "foam sanitizer" right by the door inside the room and he would "use that." RN-A stated he utilized the hand sanitizer in the room after removal of gown and gloves. RN-A identified the precautions sign on R3's door directed staff to wash hands with soap and water when leaving the room and there was a sink down the hall where staff could wash their hands. RN-A confirmed he utilized hand sanitizer when he exited R3's room, did not wash his hands with soap and water, and had subsequently gone to and touched the medication cart. RN-A stated for enteric precautions, like someone with C. diff, hand hygiene with soap and water was needed to prevent spreading infection and transmitting C. diff to another resident or even himself. During an interview on 8/27/25 at 9:46 a.m., the director of nursing (DON) stated when staff exit a room with contact enteric precautions, they need to remove their PPE and "then wash their hands." She expected staff to go out of the room and straight to an area to wash their hands. Anything touched along the way before washing hands would need to be sanitized. The DON noted	21375		

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21375	Continued from page 11 it was not okay to touch the medication cart before washing hands. With C. diff, soap and water was the standard for hand hygiene. The risk of not using soap and water for hand hygiene was the potential to spread C. diff bacteria. During an interview on 8/28/25 at 10:22 a.m., the facility's infection preventionist (IP) stated she expected staff exiting a room of a resident with C. diff to wash their hands with soap and water. The IP noted this is what she trained staff to do, what the contact enteric precaution door signs directed, and what facility policy indicated. Hand sanitizer was not effective against C. diff. The risk of not washing hands with soap and water was still having some of the contagious organism present on hands or skin, touching other surfaces or people, and spreading it to other people or oneself. Facility policy titled Infection Control dated 5/13/25, identified transmission based precautions were used in addition to standard precautions for diseases with multiple routes of transmission, including contact precautions. Contact or touch was the most common and significant mode of transmission of infectious agents and residents in contact precautions included those infected with C. diff. Facility policy titled Clostridium Difficile Infection dated 4/3/24, identified C. diff was a spore-forming bacteria found in feces and health care workers could spread the bacteria to other residents or contaminate surfaces through hand contact. Residents would be placed on contact or enhanced barrier precautions. Enhanced barrier precautions were only to be used if the resident was continent of bowel or the diarrhea could be contained in an incontinence product. Residents with acute diarrhea would be in contact precautions. A contact or enhanced barrier precautions sign was to be placed on the resident's door. Gloves would be worn prior to entering the room and removed before exiting with hand hygiene performed before putting on gloves, after removing gloves, and any time hands were visibly soiled. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review/revise policies and procedures on hand hygiene, contact precautions, and C. diff. The administrator, DON, or designee could educate all staff on these policies and procedures. The administrator, DON, or designee could conduct audits to ensure all staff members are implementing proper infection control practices when caring for residents on contact	21375		

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21375	Continued from page 12 precautions and with C. diff and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		