



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 13, 2026

Administrator
PROVIDENCE PLACE
3720 23RD AVENUE SOUTH
MINNEAPOLIS, MN 55407

RE: CCN: 245271

Cycle Start Date: May 14, 2026

Dear Administrator:

On July 17, 2026, we notified you a remedy was imposed. On August 7, 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 August 4, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 14, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 17, 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 August 14, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 4, 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 Therefore, the NATCEP prohibition is rescinded.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,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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July 17, 2026

Administrator
PROVIDENCE PLACE
3720 23RD AVENUE SOUTH
MINNEAPOLIS, MN 55407

RE: CCN: 245271

Cycle Start Date: May 14, 2026

Dear Administrator:

On June 4, 2026, we informed you that we may impose enforcement remedies.

On June 29, 2026, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance.

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

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 August 14, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 14, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 14, 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.

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.

If you have not achieved substantial compliance by August 14, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, PROVIDENCE PLACE will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 14, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

Lisa Krebs, Regional Operations Supervisor RR
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 - 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 November 14, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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 Steven Delich, Program Representative at (312) 886-5216. 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)

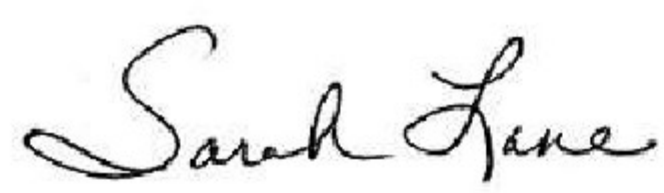
In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments 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.

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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July 17, 2026

Administrator
PROVIDENCE PLACE
3720 23RD AVENUE SOUTH
MINNEAPOLIS, MN 55407

Re: Event ID: 23714E-H1

Dear Administrator:

The above facility survey was completed on June 29, 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,

A handwritten signature in black ink that reads '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: 245271		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/29/2026	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH , MINNEAPOLIS, Minnesota, 55407			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 6/24/26, 6/25/26, 6/29/26, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52712888C (3040661) with deficiencies cited at F740. 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			07/23/2026
F0740 SS = D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility			F0740	The facility submits this Plan of Correction as its credible allegation of compliance. Preparation and submission of this Plan of Correction does not constitute an admission that the deficiencies cited existed or that they are accurately described. This Plan of Correction is submitted to meet applicable regulatory requirements. An interdisciplinary team (IDT) met with both Resident 1 (R1) and Resident 2 (R2) to identify any past trauma and determine the individual triggers that contributed to alcohol use. Based on these assessments, the IDT developed individualized interventions designed to reduce the urge to consume alcohol by incorporating activities each resident enjoys during their free time. The care plans for both R1 and R2 were revised to include the identified triggers, individualized goals, and appropriate interventions. The facility also conducted an audit of other residents with similar behavioral		08/03/2026

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0740 SS = D	Continued from page 1 failed to develop, implement, monitor, and revise individualized interventions to address alcohol-related behaviors for 2 of 2 residents (R1 and R2) reviewed for behavioral health services. Findings include: R2 R2's quarterly Minimum Data Set (MDS) dated 4/27/26, identified R2 had moderate cognitive impairment and no behaviors or rejection of care. R2's diagnoses included non-Alzheimer's dementia, anxiety, and depression. R2 was independent with his wheelchair and most activities of daily living. R2's used antidepressant medication. R2's community life care plan focus revised 4/30/25, indicated R2 self-directed leisure pursuits. R2's substance abuse care plan focus revised 8/12/25, indicated R2 drank alcohol and occasionally used cocaine. R2 was agreeable to work with LADC (licensed alcohol and drug counselor). R2's antidepressant medication care plan focus revised 2/7/26, indicated R2 had history of suicidal ideations and feelings of sadness, low self-esteem, tearfulness, withdrawal from cares/activity, ineffective coping, and feeling lonely/isolated related to depression and substance abuse mood disorder. Interventions and dates included: -4/11/25; approach every three months to discuss treatment options. -4/16/25; therapy community assessment indicates resident can be independent when leaving the facility. SLUMS score indicated concern for cognitive impairment. BIMS score indicated moderate cognitive impairment. -4/30/25; R2's preferences included cards, smoking, cooking, music, going on walks, news channels, discovery and history channels, and encouraging R2 to participate in Well-Fit program's group exercises and/or individual cardio. -5/8/25; observe behavior and attempt to determine pattern, frequency, intensity, and triggers. Offer aromatherapy. Report to nurse ongoing signs/symptoms of depression. Staff to conduct room checks to ensure resident is not smoking in his room. Encourage out of room activities that promote physical activity. -5/14/25; remind R2 of group programs, provide	F0740	Continued from page 1 health needs and updated their care plans as appropriate. To prevent recurrence, the facility revised its behavioral health care planning process to require an interdisciplinary review following any alcohol-related incident, behavioral escalation, or resident-to-resident altercation to determine whether care plan revisions are necessary and effective. The interdisciplinary team provided education to nursing staff, IDT members, and the Social Services Department regarding the requirements of F740, Behavioral Health Services, with an emphasis on identifying behavioral health needs, developing individualized interventions, and timely updating resident care plans. To ensure ongoing compliance, the Director of Nursing, Social Services Director, or designee will conduct random weekly audits of identified residents for two weeks, followed by monthly audits for one month, to verify that individualized behavioral interventions are present in the care plan, implemented as intended, and accurately documented. Audit findings will be presented to the Quality Assurance and Performance Improvement (QAPI) Committee. The QAPI Committee will review audit results, identify trends and opportunities for improvement, and implement additional corrective actions as necessary to ensure sustained compliance with behavioral health service requirements.	08/03/2026	

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F0740 SS = D	Continued from page 2 word puzzles, word searches, and pens/pencils. -9/6/25; agreed to find housing. Remain in structured safe setting such as facility to support quality of life and best functioning. Validate, listen, help problem solve, and offer reassurance when R2 expressed distress. Support sobriety and smoking cessation. Encourage meaningful activities. R2 enjoyed socializing. -10/27/25; attempt non-pharmacological interventions. -11/5/25; maintain supervision of peer interactions on the unit. If substance abuse or boundary concerns were suspected, room searches to remove substances may be appropriate to reduce harm to self and others. R2's Associated Clinic of Psychology note dated 2/26/26, identified interventions to explore ambivalence, set harm-reduction goals, cognitive restructuring for urges/boredom, and problem-solving for high-risk situations. Treatment recommendations included continued need for behavioral/environmental structure due to cognitive deficits and ongoing alcohol abuse. R2's Psychiatric Progress Note dated 4/10/26, identified R2 "continues to drink regularly from the best I can tell here". R2's provider note signed 5/16/26, identified R2 reported consumption of vodka and beer approximately once a week. R2's provider note signed 5/23/26, identified R2 had recently consumed one bottle of vodka, and R2 stated the occurrence was a "one-time" event. R2's progress notes on 5/28/26 at 8:43 p.m., 6/3/26 at 4:30 p.m., and 6/4/26 at 5:22 p.m., indicated R2 had slurred speech and a strong odor of alcohol. Staff encouraged R2 to remain on unit and return to room, held medications, notified providers, and implemented fall precautions. R1 R1's quarterly Minimum Data Set dated 5/21/26, indicated R1 was cognitively intact, had continuous inattention, and no behavior, mood, and rejection of cares. R1 was independent with ambulation and activities of daily living. R1 diagnoses included traumatic brain injury, malnutrition, depression, and psychotic disorder. R1 used antipsychotic and			F0740			08/03/2026

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F0740 SS = D	Continued from page 3 antidepressant medication. R1's care plan focus of antidepressant medication revised 11/26/25, identified R1 had diagnoses of adjustment disorder with mixed anxiety and depressed mood and unspecified mood disorder. R1's care plan focus of substance use disorder was revised 3/30/26 and identified R1 had a history of substance use disorder as evidenced by history of alcohol dependence, other stimulant dependence, and cocaine dependence. R1 was seen by in-house LADC and wavered whether he wanted to go to an inpatient treatment center. R1's care plan focus of antipsychotic medication revised 3/31/26, identified R1 yelled and swore at staff and played music loud while suspected to be under the influence. R1 told stories which were not consistent and changed based on whether he was under the influence. Interventions and dates included: -11/30/25; educate R1 on ways to utilize coping skills when feeling urge to use. Encourage frequent contact with family/friends that do not encourage substance use. -11/30/25; attempt non-pharmacological interventions, such as reassurance or validation of feelings and observe effectiveness. -12/17/25; approach every three months to discuss treatment options. Contact emergency personnel as needed. Therapy community assessment indicated no supervision was required in the community, and resident was safe to be in the community independently. -3/31/26; see behavior contract. -5/13/26; R1 agreed to work with chemical dependence counselor to determine if he should go into treatment and what might be the best options for him given his goals. When R1 expressed distress, validate his distress, listen to him, help him problem solve and offer reassurance. Work with ACP (Associated Clinic of Psychology)/psychiatry to help him work on issues bubbling up, such as historical abuse. R1's goal was to meet with LADC and attend alcoholics anonymous meetings. It was a good time to work with him on housing options. R1 was spiritual and would benefit from seeing the in-house chaplain. -5/13/26; resident continued to see both in-house ACP and psychiatry on a regular basis to manage mood and medications.			F0740			08/03/2026

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F0740 SS = D	Continued from page 4 -5/15/26; continue close monitoring of mood, alcohol related behavior, passive suicidal ideation statements, and ability to recall/report events accurately. Use calm, direct communication and reinforce safety plan, while avoiding power struggles around disputed details. R1's provider note dated 5/28/26, indicated R1 had not had any alcohol for at least a week, had a substance abuse counselor, and provider encouraged participation in support groups. R1's ACP note dated 5/28/26, indicated interventions to process grief response and improve understanding on the exacerbation of substance use disorder, explore when urges to use are stronger and less, identify coping strategies to reduce urges to use. The note indicated encouragement to continue recovery support participation, medication compliance, and monitoring sleep/energy/mood changes. R1's provider note dated 5/29/26, indicated R1 had a physical altercation while intoxicated in the smoking area around 6:00 p.m. Staff intervened before any physical contact occurred. R1's provider note dated 6/3/26, indicated R1 had altercation with another resident where the other resident pushed and kicked him. R1 was picked up by police and returned to the facility later. The note indicated R1 had an alcohol dependency counselor but rarely engaged with them, and R1 continued with AA groups. R1's progress note dated 6/10/26 at 4:23 a.m., indicated R1 and other residents were smoking in a resident's room. LPN-A smelled cigarette smoke from a resident room, told the residents to stop smoking in the room and management would be notified. LPN-A indicated he was told residents, which included R1, had an "altercation" at the front of the building which required police presence. LPN-A indicated he was not present and was helping another resident at the time of the altercation and did not meet with the police. The facility reported incident (FRI), submitted to the state agency on 6/10/26 at 4:41 p.m., identified RN-A notified the administrator of R1's progress note on 6/10/26 at 9:30 a.m. and no other staff had reported the incident to the administrator. The FRI description of incident indicated R2 stated the residents were "just 'drinking stupid'", and R1 got into a confrontation with R5. R2 reported "there were no blows and no one hit anyone", and R2 went up			F0740			08/03/2026

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F0740 SS = D	Continued from page 5 to bed after the incident. R4 indicated R1 pushed R2, and a resident was hit by a cane. R4 called the police when “things got heated”. The FRI indicated there were no known injuries. The facility outlined immediate steps taken: -Residents involved will be assessed for injury. -R2 indicated he felt safe and was not afraid of R1. -R4 was given a trauma assessment and indicated she felt safe in the facility and R1 made her anxious. -R1 will have a 1:1 while intoxicated to ensure his and others safety. R1’s progress note dated 6/10/26 at 1:53 p.m., indicated R1 had no behaviors and slept most of the shift. R1’s progress note dated 6/10/26 at 3:30 p.m., indicated R1 signed out of the facility on a leave of absence. During observation and interview on 6/24/26 at 11:19 a.m., R1 sat up in bed and stated he had been asleep. R1 stated “there had been drinking going on” when asked about the incident on 6/10/26. R1 stated there were one or two residents who had alcohol daily, and R2 had alcohol on 6/10/26. R1 stated staff did not encourage drinking and did not have to communicate to staff when drinking. R1 stated he got in a verbal altercation with a female resident recently, and staff had to shadow him for 24 hours. During observation and interview on 6/24/26 at 11:09 a.m., R2 was laying in bed with the television on. R2’s wheelchair and cane were next to his bed. R2 stated the incident on 6/10/26 was “just an argument” and “it’s nothing”. R2 stated “just some words” were said and R1 pushed him and “they say I hit [R1] with my cane”. R2 stated R1 asked him for a cigarette but he didn’t give R1 a cigarette. R2 stated the staff did not help and had asked what happened and went back into the building. During interview on 6/24/26 at 5:10 p.m., R5 stated R1 and R2 got in a fight and were yelling at each other. R5 was not sure what they fought about and stated R1 liked to fight. R5 stated “nothing happened to me” and did not remember if any staff helped on 6/10/26. During interview on 6/25/26 at 7:35 a.m., R4 stated she was present for the incident in the smoking area			F0740			08/03/2026

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F0740 SS = D	Continued from page 6 on 6/10/26. R4 stated R1 was “begging” for cigarettes most of the night and was “drunk” and “belligerent”. R4 stated R1 asked R5 for cigarettes multiple times and called R5 a “c” word. R4 and R2 tried to intervene, and R1 “snatched” a cigarette from R2’s mouth and threw the lite cigarette at R2. R1 bumped into R2, R2 stood up, and R1 pushed R2 a few times. R4 stated staff watched from the lobby and did not help when R4 waved at them to help. R4 stated R1 was “red” in the face and seemed “dangerous” and did not feel “physically” threatened by R1. R4 stated staff did not let R1 into the building for “a while”, and R4 called the police. R4 stated she escorted the police into the building and did not see any staff and left the police when they saw R1. R4 stated residents, such as R1, drink and smoke weed and should not be allowed to get to the point of affecting other residents’ quality of life. During interview on 6/25/26 at 12:38 p.m., NA-D stated she was smoking outside “down the street” when she heard “arguing and metal tables and chairs”. NA-D went into the building and looked out the window and saw residents arguing and a resident pointed to one of the male residents and waved at her. NA-D stated R1 came into the building and started to yell at her. NA-D stated she told R1 he needed to go back to his room, and R1 “got mean.” NA-D stated she knew R1’s “history” of arguing and being mean when drunk, so NA-D went into a bathroom down the hallway and locked the door. NA-D stated two other nursing assistants were doing their rounds, and R1 had fallen down a couple times. NA-D stated she waited until R1 disappeared before going back to her assigned work unit. NA-D could not remember if she told her nurse or supervisor since she was “wired” about the situation. NA-D stated there “wasn’t much I could do” about the situation with the other residents and herself. NA-D stated R1 had gotten into staff’s faces before and put his chest on staff. NA-D stated there was a time “months ago” when R1 and another resident were drinking in a resident room and were loud and other residents indicated they were scared. Staff asked R1 if he could go back to his floor, and it “took a bit” to get R1 off the floor and R1 was loud as he left the unit. During interview on 6/25/26 at 12:16 p.m., NA-C stated she came out of a resident room and saw NA-D and asked if she was okay, and NA-D indicated she was smoking outside and heard residents outside “arguing” and saying “get back”. NA-C did not see any fighting when she looked outside and saw R1 and other residents. R1 entered			F0740			08/03/2026

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F0740 SS = D	Continued from page 7 the building and was on a unit on the first floor when R1 dropped to the floor, and NA-C thought something was wrong with R1. NA-C got RN-B, and R1 got off the floor and asked NA-C if he scared her and walked off the unit while playing his music loud. R1 was intoxicated and acting like he was “on some kind of drugs or something”. R1 was loud, had slurred speech, and walked and “waddled like [a] drunk person”. NA-C stated R1 came to her unit on other nights and smoked in other residents’ rooms and swore and yelled into staff’s faces. NA-C stated staff were not trained to work with “intoxicated people” and had no way to diffuse situations of intoxicated residents. During interview on 6/24/26 at 3:15 p.m., NA-A stated she worked overnight on 6/9/26 into 6/10/26. NA-A stated the police came to the unit she worked, and she could not find a nurse to speak to. The police told NA-A a resident called the police and a resident had hit another resident. NA-A stated R1 was on the unit with the police and told the police “Don’t touch me” while being close to the police’s face and walked away. NA-A stated another nurse told her R1 had thrown himself into the elevator that night. NA-A stated she reported to LPN-A about the police presence when LPN-A returned to R1’s unit. NA-A stated R1 and R2 were “drinking together” and “seemed pretty drunk”. NA-A stated staff monitor drunk residents for safety and report to the nurse. NA-A stated nurses were supposed to intervene when residents are drunk and indicated nurses do not intervene. NA-A stated R1 required a staff one to one when intoxicated but was not consistently implemented. During follow-up interview on 6/25/26 at 4:36 p.m., NA-A stated R1 and R2 were in another resident room at the beginning of her shift on 6/9/26 and asked the evening shift nurse what was going on, and the evening shift nurse was “dismissive”. NA-A stated it was a “rare sighting” to see the three residents in the same room. NA-A stated an hour or two into her shift she smelled cigarettes from a room R1 and R2 were in together and reported to LPN-A, the overnight nurse, who told the residents to stop smoking in the room, and he was going to report the smoking to management. NA-A stated R1, R2, and the other resident “dispersed” after LPN-A spoke with them. NA-A stated R1 was aggressive and cursed when intoxicated, and R2 slept in bed most of the time she worked with him and was known to drink. During interview on 6/25/26 at 9:40 a.m., NA-B stated she worked overnight 6/9/26 into 6/10/26. NA-B stated the police came up to the unit she worked on, and the police indicated R1 hit another			F0740			08/03/2026

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F0740 SS = D	Continued from page 8 resident. NA-B stated the police indicated she was at the facility entrance for “a while” and saw no staff on the first floor to speak with. NA-B stated R1 went up to the police “aggressively” and R1 stated “he tried to hit me too”. NA-B stated she did a safety check on R1 at the start of her shift, and R1 was not in his room and did not see R1 until the police officer was present. After the police left, R1 went to his room and “calmed down”. NA-B stated they told LPN-A the police officer was present and indicated R1 and R2 were arguing and thought R1 hit R2. NA-B stated they completed a safety check on R1 at 3:00 a.m. and 5:00 a.m., and R1 was in his room both times. NA-B stated she could tell R2 was intoxicated by the way he talked and smelled and had “eyes low”. NA-B stated R2 did not talk about what happened on the smoking patio and stated he was tired and went to his room. NA-B was not aware of any new interventions for R1 or R2 since 6/10/26. During interview on 6/25/26 at 4:27 a.m., the police officer who responded to the situation on 6/10/26 stated staff indicated R1 and R2 were drinking together earlier in the day and there was an altercation between the two residents. The police advised staff to separate R1 and R2. The officer stated R1 was “always” intoxicated when she responded to calls involving him and was not close enough to R2 to determine if he was intoxicated. During interview on 6/24/26 at 2:17 p.m., LPN-A stated he was on another facility floor helping with a wound dressing when the incident occurred and the police came. LPN-A stated he heard about the incident when he returned to his assigned unit from two nursing assistants and a phone call from RN-B. LPN-A stated the police were already gone when he heard R1 was involved in an incident which caused police presence and did not know about the other residents who were involved. LPN-A stated he checked on R1 afterwards, and R1 was sleeping in bed and did not smell like alcohol. LPN-A stated R1 had a history of drinking and playing loud music in the hallways. LPN-A stated approximately two weeks ago R1 was placed on a one to one related to his behaviors. During a follow-up interview on 6/25/26 at 2:09 p.m., LPN-A stated he was not aware of any related information which would indicate the need to make an immediate report to the DON or administrator. During interview on 6/24/26 at 3:36 p.m., RN-B stated she managed the locked building door overnight by pressing a button to let people in and asked people what they were at the facility for when			F0740			08/03/2026

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F0740 SS = D	Continued from page 9 she did not recognize someone who was requesting facility entrance. RN-B stated she was not aware of a resident-to-resident altercation on 6/10/26, and the police and emergency services personnel had been at the facility a lot recently for altercations and other reasons. RN-B stated she calls the overnight supervisor to alert them of any police or emergency personnel presence, since she does not always know why they are in the facility, and the supervisor would know where to direct them. RN-B stated she did not speak with the police on 6/10/26. RN-B stated there were cameras on an electronic device which pointed out to the smoking area but was hard to see and “grainy” and no one monitored the smoking area overnight. RN-B stated R1 had walked onto her unit multiple times previously and into a resident’s room where the resident was sleeping “half the time”, and R1 would be “intoxicated”, slurring his words, and smelling like alcohol. RN-B stated they held residents’ medications when they were intoxicated and completed an assessment related to intoxication. During interview on 6/24/26 at 2:04 p.m., RN-A stated she reviewed clinical notes daily, and an investigation started when she was not sure what happened based on the note from 6/10/26 at 4:23 a.m. RN-A stated she expected staff to contact the DON or administrator immediately of any verbal or physical altercation but did not believe LPN-A knew what happened at the time of the incident. During interview on 6/24/26 at 1:50 p.m., the administrator stated he was in the morning interdisciplinary meeting around 9:30 a.m. on 6/10/26 when RN-A read the progress note and notified him. The administrator stated the progress note was “vague”, so he and the assistant executive director started to investigate what happened. The administrator stated they interviewed the involved residents and LPN-A and reviewed the facility’s camera footage. The administrator stated R1 was close to R2’s face because R1 wanted a cigarette, and R2 hit R1 one or two times with his cane. R1 went into the building after the altercation. The police showed up around 12:45 a.m. on 6/10/26 and did not see staff during the incident. The facility five-day Investigation Report Summary, submitted to the state agency on 6/16/26 at 4:40 p.m., identified the altercation occurred at the facility on the smoking patio through witness interview and security camera footage. The facility interviewed R1, R2, R4, and R5. The summary of interviews with witness(es) indicated R1 would not leave R2’s “personal space”, and R2 hit R1 with a cane. R1			F0740			08/03/2026

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F0740 SS = D	Continued from page 10 walked away from the smoking patio and entered the building where he met with staff who were on their way to diffuse the situation. R4 called the police when R2 hit R1 with a cane. The facility interviewed LPN-A, the nurse of R1 and R2 on the overnight shift of 6/9/26 into 6/10/26, and LPN-A indicated he was helping another nurse, and the police had already left the building when he heard about the situation. LPN-A indicated he observed R1 in R1's bed, and R1 did not smell like alcohol at the time. The facility educated the involved residents on the importance of respecting each other and to not get into arguments or will be separated. The residents were educated on the importance of not sharing cigarettes with other residents. The facility was assisting R1 to discharge to a less "retractive community/ Low-income housing". R1's intervention under the antidepressant medication care plan focus revised 6/16/26, identified R1 had insight he was not functioning well neurologically, writing things down for R1 and encouraging him to write things down helped R1 to remember things, R1 agreed seeing friends was helpful and struggled to identify and initiate activities to improve mood, would benefit from being invited to attend things, encourage enrollment in a treatment program, use calm and direct communication while avoiding power struggle. R1's ACP note dated 6/18/26, indicated R1 was six days sober and recommended to reinforce prosocial behavior and routines to support sobriety. R2's SUD (substance use disorder) Facility Evaluation of Impairment – V2 dated 6/19/26, indicated R2 had odor of alcohol or marijuana present, slurred speech, and mood changes. R2 had a clear cup of unidentified liquid and confirmed he consumed alcohol. Staff notified the nurse practitioner, placed hold on medications, increased monitoring and/or observation of condition, encouraged resident to stay in room, made sure environment free of obstacles, adjusted bed to appropriate height, and observed for withdrawal symptoms. During interview on 6/24/26 at 2:43 p.m., the assistant executive director (ED)-A stated he interviewed the overnight nurse supervisor, who was also the direct overnight nurse of R1 and R2, and no other staff. ED-A stated LPN-A and facility staff received education about reporting incidents and timing of reporting since 6/10/26. ED-A stated the two residents were separated after the incident, and R1 went on a leave of absence the morning of			F0740			08/03/2026

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F0740 SS = D	Continued from page 11 6/10/26 and had no other issues since 6/10/26. ED-A stated residents were monitored on the smoking area with camera footage, and residents were required to have an assessment to be independent in the smoking area or out in the community. During follow-up interview on 6/25/26 at 9:22 a.m., ED-A stated R1 had a history of picking fights when intoxicated and this was R1's first fight when not intoxicated. ED-A stated R1 was not intoxicated according to LPN-A. ED-A stated R1 required a staff one to one when intoxicated through the facility SUD assessment. ED-A expected staff to complete the SUD assessment when residents returned to the facility after being in the community or when staff noticed signs and/or symptoms of intoxication. ED-A stated R1 had supportive services. ED-A stated R1 wanted to discharge and worked with R1 to find housing. ED-A stated R2 had not had any previous interactions with other residents like on 6/10/26. During interview on 6/25/26 at 7:01 a.m., NA-E stated R1 fought when intoxicated and staff tried to calm him down when behaviors occurred. R1 was not easy to calm and ran after staff previously. NA-E stated R2 gets intoxicated but did not fight with others. NA-E guided residents to go to their room when they were loud or yelling at staff or appeared intoxicated and notified the nurse of concerns. During interview on 6/25/26 at 2:42 p.m., NA-F stated R2 slept a lot the evening of 6/9/26, and R1 was independent. NA-F stated they were not aware of resident-specific care plan interventions regarding intoxication management for R1 or R2. During interview on 6/24/26 at 12:53 p.m., LPN-B stated he performed a SUD assessment if a resident appeared intoxicated, notified the provider, held medications, monitored resident and maintained safety. LPN-B stated a couple weeks ago he received education of the African American Survival Services and could call the service when residents were intoxicated or disruptive to the community. LPN-B stated he would call the DON or administrator after calling the service. During interview on 6/25/26 at 7:14 a.m., RN-C stated R2 had slurred speech and incontinent when drinking. RN-C stated R2 made comments such as "oh hunny" and "I like to see you walking away" and was not physically or verbally aggressive or fought with others. RN-C stated staff document behaviors under progress notes. RN-C stated she			F0740			08/03/2026

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F0740 SS = D	Continued from page 12 received report of R2 drinking once or twice in a two-week period, and R2 smoked out his bedroom window even though he knew he was not supposed to. RN-C stated she would document resident 1 to 1s implementation in a progress note. During interview on 6/24/26 at 1:01 p.m., social worker (SW)-A stated she completed an assessment on R2 after the incident to make sure R2 was safe. R2 confirmed he felt safe and did not want any extra precautions taken, such as moving rooms or staying away from R1. SW-A stated ACP and LACD and peer recovery group followed up with all residents involved with the 6/10/26 incident, and the social workers updated care plans based on ACP or LADC notes. SW-A stated there were no care plan changes she was aware of after the incident. R1's intervention under the substance use disorder care plan focus dated 6/25/26, directed staff to continue reinforcing prosocial behavior and routines to support sobriety. During interview on 6/25/26 at 4:17 p.m., the long-term care assistant director of nursing (ADON) stated multiple staff managed the substance use disorder unit. The ADON reviewed R1's care plan and was unsure what "prosocial" behavior meant. ADON indicated a website browser search identified prosocial behavior meant encourage to interact and socialize with others. During joint interview on 6/29/26 at 10:02 am with the director of nursing (DON), ED-A, administrator, and SW-B, R1 care plan and behavioral services were reviewed. R1's behavioral contract was part of R1's care plan from the previous regional director of operation and was not sure what the behavioral contract with R1 was. "Prosocial" behavior and routines that support sobriety meant to encourage R1 if he was having a good day and "boost" him up and tell him he looks good. Staff were to encourage R1 to talk about how he was doing. R1 liked to socialize and not talk about his feelings. The facility representatives reviewed no R1 activity recommendations plan despite the interventions in which R1 struggled to identify and initiate activities to improve mood and would benefit from being invited to attend things. The facility representatives stated R1 spent time outside the facility and directed his own activities. R1's activities were reviewed at quarterly care conferences, and activities were tracked by the community of life team. Facility representatives stated African American Survivor Services and LASD were confidential services unless R1 was willing to share information. The staff were			F0740			08/03/2026

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F0740 SS = D	Continued from page 13 educated they could call African American Survivor Services 24/7 if a resident showed signs/symptoms of intoxication or having “a hard time” and could take residents on outings and car rides. The team reviewed the intervention to “utilize coping skills” and stated they could only specify trigger or coping skills if R1 shared with the facility staff. The team helped R1 focus on meetings for the week related to substance use and encouraged him to participate. During continued interview, R2’s care plan and behavioral services were reviewed. The team verified there were no changes in R2’s care plan after the 6/10/26 incident. The team stated R2 was offered LASD and ACP visits and other group meetings. R2 was not open to most services offered besides African American Survivor Services. The African American Survivor Services organizer met with residents at the facility twice a week, but the meeting notes were confidential and not viewable to the facility. The team verified the care plan did not specify R2’s triggers for alcohol use and stated asking R2 about his drinking triggers could be a trigger itself. Staff were to monitor R2 for signs/symptoms of substance use, and R2 was not willing to share his triggers with the facility. The team verified R2’s records did not indicate his target behaviors or non-pharmacological interventions for behaviors. The team stated they have a PIP (Personal improvement plan) to look at psychotropic medications, target behaviors, and nonpharmacological interventions. The management team expected staff to notify them immediately of events such as the one which occurred between R1 and R2 on 6/10/26, because immediate follow-up for residents was important to promote the best possible psychosocial wellbeing. R1’s Mood and Behavior Review assessment dated 2/18/26, identified R1 used antipsychotic and antidepressant medication. R1 had verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others. The assessment did not fill in the area to indicate review of current target behaviors and resident specific interventions. The assessment indicated redirection was generally effective for R1’s mood and behaviors. R1’s Care Conference Summary Resident Profile dated 5/21/26, identified a care conference occurred on 6/3/26 and Community Life section was not filled in. The Care Conference Summary’s signature and date section was blank. The facility did not provide activity tracking for R1 from the community of life team.			F0740			08/03/2026

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F0740 SS = D	Continued from page 14 The facility did not provide a recent care conference summary for R2 or activity tracking for R2 from the community of life team. The facility Behavioral Health Services policy dated 4/1/26, indicated a resident care plan will have person-centered, evidence-based, trauma-informed interventions. The policy directed the facility to provide meaningful activities to promote engagement and positive, meaningful relationships. The policy directed the facility to review and revise the care plan as needed, such as when interventions were not effective or when the resident experienced a change of condition.			F0740			08/03/2026

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F0000	INITIAL COMMENTS On 6/24/26, 6/25/26, 6/29/26, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52712888C (3040661) with deficiencies cited at F740. 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			07/23/2026
F0740 SS = D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility			F0740	The facility submits this Plan of Correction as its credible allegation of compliance. Preparation and submission of this Plan of Correction does not constitute an admission that the deficiencies cited existed or that they are accurately described. This Plan of Correction is submitted to meet applicable regulatory requirements. An interdisciplinary team (IDT) met with both Resident 1 (R1) and Resident 2 (R2) to identify any past trauma and determine the individual triggers that contributed to alcohol use. Based on these assessments, the IDT developed individualized interventions designed to reduce the urge to consume alcohol by incorporating activities each resident enjoys during their free time. The care plans for both R1 and R2 were revised to include the identified triggers, individualized goals, and appropriate interventions. The facility also conducted an audit of other residents with similar behavioral		08/03/2026

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

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F0740 SS = D	Continued from page 1 failed to develop, implement, monitor, and revise individualized interventions to address alcohol-related behaviors for 2 of 2 residents (R1 and R2) reviewed for behavioral health services. Findings include: R2 R2's quarterly Minimum Data Set (MDS) dated 4/27/26, identified R2 had moderate cognitive impairment and no behaviors or rejection of care. R2's diagnoses included non-Alzheimer's dementia, anxiety, and depression. R2 was independent with his wheelchair and most activities of daily living. R2's used antidepressant medication. R2's community life care plan focus revised 4/30/25, indicated R2 self-directed leisure pursuits. R2's substance abuse care plan focus revised 8/12/25, indicated R2 drank alcohol and occasionally used cocaine. R2 was agreeable to work with LADC (licensed alcohol and drug counselor). R2's antidepressant medication care plan focus revised 2/7/26, indicated R2 had history of suicidal ideations and feelings of sadness, low self-esteem, tearfulness, withdrawal from cares/activity, ineffective coping, and feeling lonely/isolated related to depression and substance abuse mood disorder. Interventions and dates included: -4/11/25; approach every three months to discuss treatment options. -4/16/25; therapy community assessment indicates resident can be independent when leaving the facility. SLUMS score indicated concern for cognitive impairment. BIMS score indicated moderate cognitive impairment. -4/30/25; R2's preferences included cards, smoking, cooking, music, going on walks, news channels, discovery and history channels, and encouraging R2 to participate in Well-Fit program's group exercises and/or individual cardio. -5/8/25; observe behavior and attempt to determine pattern, frequency, intensity, and triggers. Offer aromatherapy. Report to nurse ongoing signs/symptoms of depression. Staff to conduct room checks to ensure resident is not smoking in his room. Encourage out of room activities that promote physical activity. -5/14/25; remind R2 of group programs, provide			F0740	Continued from page 1 health needs and updated their care plans as appropriate. To prevent recurrence, the facility revised its behavioral health care planning process to require an interdisciplinary review following any alcohol-related incident, behavioral escalation, or resident-to-resident altercation to determine whether care plan revisions are necessary and effective. The interdisciplinary team provided education to nursing staff, IDT members, and the Social Services Department regarding the requirements of F740, Behavioral Health Services, with an emphasis on identifying behavioral health needs, developing individualized interventions, and timely updating resident care plans. To ensure ongoing compliance, the Director of Nursing, Social Services Director, or designee will conduct random weekly audits of identified residents for two weeks, followed by monthly audits for one month, to verify that individualized behavioral interventions are present in the care plan, implemented as intended, and accurately documented. Audit findings will be presented to the Quality Assurance and Performance Improvement (QAPI) Committee. The QAPI Committee will review audit results, identify trends and opportunities for improvement, and implement additional corrective actions as necessary to ensure sustained compliance with behavioral health service requirements.		08/03/2026

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F0740 SS = D	Continued from page 2 word puzzles, word searches, and pens/pencils. -9/6/25; agreed to find housing. Remain in structured safe setting such as facility to support quality of life and best functioning. Validate, listen, help problem solve, and offer reassurance when R2 expressed distress. Support sobriety and smoking cessation. Encourage meaningful activities. R2 enjoyed socializing. -10/27/25; attempt non-pharmacological interventions. -11/5/25; maintain supervision of peer interactions on the unit. If substance abuse or boundary concerns were suspected, room searches to remove substances may be appropriate to reduce harm to self and others. R2's Associated Clinic of Psychology note dated 2/26/26, identified interventions to explore ambivalence, set harm-reduction goals, cognitive restructuring for urges/boredom, and problem-solving for high-risk situations. Treatment recommendations included continued need for behavioral/environmental structure due to cognitive deficits and ongoing alcohol abuse. R2's Psychiatric Progress Note dated 4/10/26, identified R2 "continues to drink regularly from the best I can tell here". R2's provider note signed 5/16/26, identified R2 reported consumption of vodka and beer approximately once a week. R2's provider note signed 5/23/26, identified R2 had recently consumed one bottle of vodka, and R2 stated the occurrence was a "one-time" event. R2's progress notes on 5/28/26 at 8:43 p.m., 6/3/26 at 4:30 p.m., and 6/4/26 at 5:22 p.m., indicated R2 had slurred speech and a strong odor of alcohol. Staff encouraged R2 to remain on unit and return to room, held medications, notified providers, and implemented fall precautions. R1 R1's quarterly Minimum Data Set dated 5/21/26, indicated R1 was cognitively intact, had continuous inattention, and no behavior, mood, and rejection of cares. R1 was independent with ambulation and activities of daily living. R1 diagnoses included traumatic brain injury, malnutrition, depression, and psychotic disorder. R1 used antipsychotic and			F0740			08/03/2026

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F0740 SS = D	Continued from page 3 antidepressant medication. R1's care plan focus of antidepressant medication revised 11/26/25, identified R1 had diagnoses of adjustment disorder with mixed anxiety and depressed mood and unspecified mood disorder. R1's care plan focus of substance use disorder was revised 3/30/26 and identified R1 had a history of substance use disorder as evidenced by history of alcohol dependence, other stimulant dependence, and cocaine dependence. R1 was seen by in-house LADC and wavered whether he wanted to go to an inpatient treatment center. R1's care plan focus of antipsychotic medication revised 3/31/26, identified R1 yelled and swore at staff and played music loud while suspected to be under the influence. R1 told stories which were not consistent and changed based on whether he was under the influence. Interventions and dates included: -11/30/25; educate R1 on ways to utilize coping skills when feeling urge to use. Encourage frequent contact with family/friends that do not encourage substance use. -11/30/25; attempt non-pharmacological interventions, such as reassurance or validation of feelings and observe effectiveness. -12/17/25; approach every three months to discuss treatment options. Contact emergency personnel as needed. Therapy community assessment indicated no supervision was required in the community, and resident was safe to be in the community independently. -3/31/26; see behavior contract. -5/13/26; R1 agreed to work with chemical dependence counselor to determine if he should go into treatment and what might be the best options for him given his goals. When R1 expressed distress, validate his distress, listen to him, help him problem solve and offer reassurance. Work with ACP (Associated Clinic of Psychology)/psychiatry to help him work on issues bubbling up, such as historical abuse. R1's goal was to meet with LADC and attend alcoholics anonymous meetings. It was a good time to work with him on housing options. R1 was spiritual and would benefit from seeing the in-house chaplain. -5/13/26; resident continued to see both in-house ACP and psychiatry on a regular basis to manage mood and medications.			F0740			08/03/2026

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F0740 SS = D	Continued from page 4 -5/15/26; continue close monitoring of mood, alcohol related behavior, passive suicidal ideation statements, and ability to recall/report events accurately. Use calm, direct communication and reinforce safety plan, while avoiding power struggles around disputed details. R1's provider note dated 5/28/26, indicated R1 had not had any alcohol for at least a week, had a substance abuse counselor, and provider encouraged participation in support groups. R1's ACP note dated 5/28/26, indicated interventions to process grief response and improve understanding on the exacerbation of substance use disorder, explore when urges to use are stronger and less, identify coping strategies to reduce urges to use. The note indicated encouragement to continue recovery support participation, medication compliance, and monitoring sleep/energy/mood changes. R1's provider note dated 5/29/26, indicated R1 had a physical altercation while intoxicated in the smoking area around 6:00 p.m. Staff intervened before any physical contact occurred. R1's provider note dated 6/3/26, indicated R1 had altercation with another resident where the other resident pushed and kicked him. R1 was picked up by police and returned to the facility later. The note indicated R1 had an alcohol dependency counselor but rarely engaged with them, and R1 continued with AA groups. R1's progress note dated 6/10/26 at 4:23 a.m., indicated R1 and other residents were smoking in a resident's room. LPN-A smelled cigarette smoke from a resident room, told the residents to stop smoking in the room and management would be notified. LPN-A indicated he was told residents, which included R1, had an "altercation" at the front of the building which required police presence. LPN-A indicated he was not present and was helping another resident at the time of the altercation and did not meet with the police. The facility reported incident (FRI), submitted to the state agency on 6/10/26 at 4:41 p.m., identified RN-A notified the administrator of R1's progress note on 6/10/26 at 9:30 a.m. and no other staff had reported the incident to the administrator. The FRI description of incident indicated R2 stated the residents were "just 'drinking stupid'", and R1 got into a confrontation with R5. R2 reported "there were no blows and no one hit anyone", and R2 went up			F0740			08/03/2026

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F0740 SS = D	Continued from page 5 to bed after the incident. R4 indicated R1 pushed R2, and a resident was hit by a cane. R4 called the police when “things got heated”. The FRI indicated there were no known injuries. The facility outlined immediate steps taken: -Residents involved will be assessed for injury. -R2 indicated he felt safe and was not afraid of R1. -R4 was given a trauma assessment and indicated she felt safe in the facility and R1 made her anxious. -R1 will have a 1:1 while intoxicated to ensure his and others safety. R1's progress note dated 6/10/26 at 1:53 p.m., indicated R1 had no behaviors and slept most of the shift. R1's progress note dated 6/10/26 at 3:30 p.m., indicated R1 signed out of the facility on a leave of absence. During observation and interview on 6/24/26 at 11:19 a.m., R1 sat up in bed and stated he had been asleep. R1 stated “there had been drinking going on” when asked about the incident on 6/10/26. R1 stated there were one or two residents who had alcohol daily, and R2 had alcohol on 6/10/26. R1 stated staff did not encourage drinking and did not have to communicate to staff when drinking. R1 stated he got in a verbal altercation with a female resident recently, and staff had to shadow him for 24 hours. During observation and interview on 6/24/26 at 11:09 a.m., R2 was laying in bed with the television on. R2's wheelchair and cane were next to his bed. R2 stated the incident on 6/10/26 was “just an argument” and “it's nothing”. R2 stated “just some words” were said and R1 pushed him and “they say I hit [R1] with my cane”. R2 stated R1 asked him for a cigarette but he didn't give R1 a cigarette. R2 stated the staff did not help and had asked what happened and went back into the building. During interview on 6/24/26 at 5:10 p.m., R5 stated R1 and R2 got in a fight and were yelling at each other. R5 was not sure what they fought about and stated R1 liked to fight. R5 stated “nothing happened to me” and did not remember if any staff helped on 6/10/26. During interview on 6/25/26 at 7:35 a.m., R4 stated she was present for the incident in the smoking area			F0740			08/03/2026

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F0740 SS = D	Continued from page 6 on 6/10/26. R4 stated R1 was “begging” for cigarettes most of the night and was “drunk” and “belligerent”. R4 stated R1 asked R5 for cigarettes multiple times and called R5 a “c” word. R4 and R2 tried to intervene, and R1 “snatched” a cigarette from R2’s mouth and threw the lite cigarette at R2. R1 bumped into R2, R2 stood up, and R1 pushed R2 a few times. R4 stated staff watched from the lobby and did not help when R4 waved at them to help. R4 stated R1 was “red” in the face and seemed “dangerous” and did not feel “physically” threatened by R1. R4 stated staff did not let R1 into the building for “a while”, and R4 called the police. R4 stated she escorted the police into the building and did not see any staff and left the police when they saw R1. R4 stated residents, such as R1, drink and smoke weed and should not be allowed to get to the point of affecting other residents’ quality of life. During interview on 6/25/26 at 12:38 p.m., NA-D stated she was smoking outside “down the street” when she heard “arguing and metal tables and chairs”. NA-D went into the building and looked out the window and saw residents arguing and a resident pointed to one of the male residents and waved at her. NA-D stated R1 came into the building and started to yell at her. NA-D stated she told R1 he needed to go back to his room, and R1 “got mean.” NA-D stated she knew R1’s “history” of arguing and being mean when drunk, so NA-D went into a bathroom down the hallway and locked the door. NA-D stated two other nursing assistants were doing their rounds, and R1 had fallen down a couple times. NA-D stated she waited until R1 disappeared before going back to her assigned work unit. NA-D could not remember if she told her nurse or supervisor since she was “wired” about the situation. NA-D stated there “wasn’t much I could do” about the situation with the other residents and herself. NA-D stated R1 had gotten into staff’s faces before and put his chest on staff. NA-D stated there was a time “months ago” when R1 and another resident were drinking in a resident room and were loud and other residents indicated they were scared. Staff asked R1 if he could go back to his floor, and it “took a bit” to get R1 off the floor and R1 was loud as he left the unit. During interview on 6/25/26 at 12:16 p.m., NA-C stated she came out of a resident room and saw NA-D and asked if she was okay, and NA-D indicated she was smoking outside and heard residents outside “arguing” and saying “get back”. NA-C did not see any fighting when she looked outside and saw R1 and other residents. R1 entered			F0740			08/03/2026

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F0740 SS = D	Continued from page 7 the building and was on a unit on the first floor when R1 dropped to the floor, and NA-C thought something was wrong with R1. NA-C got RN-B, and R1 got off the floor and asked NA-C if he scared her and walked off the unit while playing his music loud. R1 was intoxicated and acting like he was “on some kind of drugs or something”. R1 was loud, had slurred speech, and walked and “waddled like [a] drunk person”. NA-C stated R1 came to her unit on other nights and smoked in other residents’ rooms and swore and yelled into staff’s faces. NA-C stated staff were not trained to work with “intoxicated people” and had no way to diffuse situations of intoxicated residents. During interview on 6/24/26 at 3:15 p.m., NA-A stated she worked overnight on 6/9/26 into 6/10/26. NA-A stated the police came to the unit she worked, and she could not find a nurse to speak to. The police told NA-A a resident called the police and a resident had hit another resident. NA-A stated R1 was on the unit with the police and told the police “Don’t touch me” while being close to the police’s face and walked away. NA-A stated another nurse told her R1 had thrown himself into the elevator that night. NA-A stated she reported to LPN-A about the police presence when LPN-A returned to R1’s unit. NA-A stated R1 and R2 were “drinking together” and “seemed pretty drunk”. NA-A stated staff monitor drunk residents for safety and report to the nurse. NA-A stated nurses were supposed to intervene when residents are drunk and indicated nurses do not intervene. NA-A stated R1 required a staff one to one when intoxicated but was not consistently implemented. During follow-up interview on 6/25/26 at 4:36 p.m., NA-A stated R1 and R2 were in another resident room at the beginning of her shift on 6/9/26 and asked the evening shift nurse what was going on, and the evening shift nurse was “dismissive”. NA-A stated it was a “rare sighting” to see the three residents in the same room. NA-A stated an hour or two into her shift she smelled cigarettes from a room R1 and R2 were in together and reported to LPN-A, the overnight nurse, who told the residents to stop smoking in the room, and he was going to report the smoking to management. NA-A stated R1, R2, and the other resident “dispersed” after LPN-A spoke with them. NA-A stated R1 was aggressive and cursed when intoxicated, and R2 slept in bed most of the time she worked with him and was known to drink. During interview on 6/25/26 at 9:40 a.m., NA-B stated she worked overnight 6/9/26 into 6/10/26. NA-B stated the police came up to the unit she worked on, and the police indicated R1 hit another			F0740			08/03/2026

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F0740 SS = D	Continued from page 8 resident. NA-B stated the police indicated she was at the facility entrance for “a while” and saw no staff on the first floor to speak with. NA-B stated R1 went up to the police “aggressively” and R1 stated “he tried to hit me too”. NA-B stated she did a safety check on R1 at the start of her shift, and R1 was not in his room and did not see R1 until the police officer was present. After the police left, R1 went to his room and “calmed down”. NA-B stated they told LPN-A the police officer was present and indicated R1 and R2 were arguing and thought R1 hit R2. NA-B stated they completed a safety check on R1 at 3:00 a.m. and 5:00 a.m., and R1 was in his room both times. NA-B stated she could tell R2 was intoxicated by the way he talked and smelled and had “eyes low”. NA-B stated R2 did not talk about what happened on the smoking patio and stated he was tired and went to his room. NA-B was not aware of any new interventions for R1 or R2 since 6/10/26. During interview on 6/25/26 at 4:27 a.m., the police officer who responded to the situation on 6/10/26 stated staff indicated R1 and R2 were drinking together earlier in the day and there was an altercation between the two residents. The police advised staff to separate R1 and R2. The officer stated R1 was “always” intoxicated when she responded to calls involving him and was not close enough to R2 to determine if he was intoxicated. During interview on 6/24/26 at 2:17 p.m., LPN-A stated he was on another facility floor helping with a wound dressing when the incident occurred and the police came. LPN-A stated he heard about the incident when he returned to his assigned unit from two nursing assistants and a phone call from RN-B. LPN-A stated the police were already gone when he heard R1 was involved in an incident which caused police presence and did not know about the other residents who were involved. LPN-A stated he checked on R1 afterwards, and R1 was sleeping in bed and did not smell like alcohol. LPN-A stated R1 had a history of drinking and playing loud music in the hallways. LPN-A stated approximately two weeks ago R1 was placed on a one to one related to his behaviors. During a follow-up interview on 6/25/26 at 2:09 p.m., LPN-A stated he was not aware of any related information which would indicate the need to make an immediate report to the DON or administrator. During interview on 6/24/26 at 3:36 p.m., RN-B stated she managed the locked building door overnight by pressing a button to let people in and asked people what they were at the facility for when			F0740			08/03/2026

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F0740 SS = D	Continued from page 9 she did not recognize someone who was requesting facility entrance. RN-B stated she was not aware of a resident-to-resident altercation on 6/10/26, and the police and emergency services personnel had been at the facility a lot recently for altercations and other reasons. RN-B stated she calls the overnight supervisor to alert them of any police or emergency personnel presence, since she does not always know why they are in the facility, and the supervisor would know where to direct them. RN-B stated she did not speak with the police on 6/10/26. RN-B stated there were cameras on an electronic device which pointed out to the smoking area but was hard to see and “grainy” and no one monitored the smoking area overnight. RN-B stated R1 had walked onto her unit multiple times previously and into a resident’s room where the resident was sleeping “half the time”, and R1 would be “intoxicated”, slurring his words, and smelling like alcohol. RN-B stated they held residents’ medications when they were intoxicated and completed an assessment related to intoxication. During interview on 6/24/26 at 2:04 p.m., RN-A stated she reviewed clinical notes daily, and an investigation started when she was not sure what happened based on the note from 6/10/26 at 4:23 a.m. RN-A stated she expected staff to contact the DON or administrator immediately of any verbal or physical altercation but did not believe LPN-A knew what happened at the time of the incident. During interview on 6/24/26 at 1:50 p.m., the administrator stated he was in the morning interdisciplinary meeting around 9:30 a.m. on 6/10/26 when RN-A read the progress note and notified him. The administrator stated the progress note was “vague”, so he and the assistant executive director started to investigate what happened. The administrator stated they interviewed the involved residents and LPN-A and reviewed the facility’s camera footage. The administrator stated R1 was close to R2’s face because R1 wanted a cigarette, and R2 hit R1 one or two times with his cane. R1 went into the building after the altercation. The police showed up around 12:45 a.m. on 6/10/26 and did not see staff during the incident. The facility five-day Investigation Report Summary, submitted to the state agency on 6/16/26 at 4:40 p.m., identified the altercation occurred at the facility on the smoking patio through witness interview and security camera footage. The facility interviewed R1, R2, R4, and R5. The summary of interviews with witness(es) indicated R1 would not leave R2’s “personal space”, and R2 hit R1 with a cane. R1			F0740			08/03/2026

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F0740 SS = D	Continued from page 10 walked away from the smoking patio and entered the building where he met with staff who were on their way to diffuse the situation. R4 called the police when R2 hit R1 with a cane. The facility interviewed LPN-A, the nurse of R1 and R2 on the overnight shift of 6/9/26 into 6/10/26, and LPN-A indicated he was helping another nurse, and the police had already left the building when he heard about the situation. LPN-A indicated he observed R1 in R1's bed, and R1 did not smell like alcohol at the time. The facility educated the involved residents on the importance of respecting each other and to not get into arguments or will be separated. The residents were educated on the importance of not sharing cigarettes with other residents. The facility was assisting R1 to discharge to a less "retractive community/ Low-income housing". R1's intervention under the antidepressant medication care plan focus revised 6/16/26, identified R1 had insight he was not functioning well neurologically, writing things down for R1 and encouraging him to write things down helped R1 to remember things, R1 agreed seeing friends was helpful and struggled to identify and initiate activities to improve mood, would benefit from being invited to attend things, encourage enrollment in a treatment program, use calm and direct communication while avoiding power struggle. R1's ACP note dated 6/18/26, indicated R1 was six days sober and recommended to reinforce prosocial behavior and routines to support sobriety. R2's SUD (substance use disorder) Facility Evaluation of Impairment – V2 dated 6/19/26, indicated R2 had odor of alcohol or marijuana present, slurred speech, and mood changes. R2 had a clear cup of unidentified liquid and confirmed he consumed alcohol. Staff notified the nurse practitioner, placed hold on medications, increased monitoring and/or observation of condition, encouraged resident to stay in room, made sure environment free of obstacles, adjusted bed to appropriate height, and observed for withdrawal symptoms. During interview on 6/24/26 at 2:43 p.m., the assistant executive director (ED)-A stated he interviewed the overnight nurse supervisor, who was also the direct overnight nurse of R1 and R2, and no other staff. ED-A stated LPN-A and facility staff received education about reporting incidents and timing of reporting since 6/10/26. ED-A stated the two residents were separated after the incident, and R1 went on a leave of absence the morning of			F0740			08/03/2026

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F0740 SS = D	Continued from page 11 6/10/26 and had no other issues since 6/10/26. ED-A stated residents were monitored on the smoking area with camera footage, and residents were required to have an assessment to be independent in the smoking area or out in the community. During follow-up interview on 6/25/26 at 9:22 a.m., ED-A stated R1 had a history of picking fights when intoxicated and this was R1's first fight when not intoxicated. ED-A stated R1 was not intoxicated according to LPN-A. ED-A stated R1 required a staff one to one when intoxicated through the facility SUD assessment. ED-A expected staff to complete the SUD assessment when residents returned to the facility after being in the community or when staff noticed signs and/or symptoms of intoxication. ED-A stated R1 had supportive services. ED-A stated R1 wanted to discharge and worked with R1 to find housing. ED-A stated R2 had not had any previous interactions with other residents like on 6/10/26. During interview on 6/25/26 at 7:01 a.m., NA-E stated R1 fought when intoxicated and staff tried to calm him down when behaviors occurred. R1 was not easy to calm and ran after staff previously. NA-E stated R2 gets intoxicated but did not fight with others. NA-E guided residents to go to their room when they were loud or yelling at staff or appeared intoxicated and notified the nurse of concerns. During interview on 6/25/26 at 2:42 p.m., NA-F stated R2 slept a lot the evening of 6/9/26, and R1 was independent. NA-F stated they were not aware of resident-specific care plan interventions regarding intoxication management for R1 or R2. During interview on 6/24/26 at 12:53 p.m., LPN-B stated he performed a SUD assessment if a resident appeared intoxicated, notified the provider, held medications, monitored resident and maintained safety. LPN-B stated a couple weeks ago he received education of the African American Survival Services and could call the service when residents were intoxicated or disruptive to the community. LPN-B stated he would call the DON or administrator after calling the service. During interview on 6/25/26 at 7:14 a.m., RN-C stated R2 had slurred speech and incontinent when drinking. RN-C stated R2 made comments such as "oh hunny" and "I like to see you walking away" and was not physically or verbally aggressive or fought with others. RN-C stated staff document behaviors under progress notes. RN-C stated she			F0740			08/03/2026

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F0740 SS = D	Continued from page 12 received report of R2 drinking once or twice in a two-week period, and R2 smoked out his bedroom window even though he knew he was not supposed to. RN-C stated she would document resident 1 to 1s implementation in a progress note. During interview on 6/24/26 at 1:01 p.m., social worker (SW)-A stated she completed an assessment on R2 after the incident to make sure R2 was safe. R2 confirmed he felt safe and did not want any extra precautions taken, such as moving rooms or staying away from R1. SW-A stated ACP and LACD and peer recovery group followed up with all residents involved with the 6/10/26 incident, and the social workers updated care plans based on ACP or LADC notes. SW-A stated there were no care plan changes she was aware of after the incident. R1's intervention under the substance use disorder care plan focus dated 6/25/26, directed staff to continue reinforcing prosocial behavior and routines to support sobriety. During interview on 6/25/26 at 4:17 p.m., the long-term care assistant director of nursing (ADON) stated multiple staff managed the substance use disorder unit. The ADON reviewed R1's care plan and was unsure what "prosocial" behavior meant. ADON indicated a website browser search identified prosocial behavior meant encourage to interact and socialize with others. During joint interview on 6/29/26 at 10:02 am with the director of nursing (DON), ED-A, administrator, and SW-B, R1 care plan and behavioral services were reviewed. R1's behavioral contract was part of R1's care plan from the previous regional director of operation and was not sure what the behavioral contract with R1 was. "Prosocial" behavior and routines that support sobriety meant to encourage R1 if he was having a good day and "boost" him up and tell him he looks good. Staff were to encourage R1 to talk about how he was doing. R1 liked to socialize and not talk about his feelings. The facility representatives reviewed no R1 activity recommendations plan despite the interventions in which R1 struggled to identify and initiate activities to improve mood and would benefit from being invited to attend things. The facility representatives stated R1 spent time outside the facility and directed his own activities. R1's activities were reviewed at quarterly care conferences, and activities were tracked by the community of life team. Facility representatives stated African American Survivor Services and LASD were confidential services unless R1 was willing to share information. The staff were			F0740			08/03/2026

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F0740 SS = D	Continued from page 13 educated they could call African American Survivor Services 24/7 if a resident showed signs/symptoms of intoxication or having “a hard time” and could take residents on outings and car rides. The team reviewed the intervention to “utilize coping skills” and stated they could only specify trigger or coping skills if R1 shared with the facility staff. The team helped R1 focus on meetings for the week related to substance use and encouraged him to participate. During continued interview, R2's care plan and behavioral services were reviewed. The team verified there were no changes in R2's care plan after the 6/10/26 incident. The team stated R2 was offered LASD and ACP visits and other group meetings. R2 was not open to most services offered besides African American Survivor Services. The African American Survivor Services organizer met with residents at the facility twice a week, but the meeting notes were confidential and not viewable to the facility. The team verified the care plan did not specify R2's triggers for alcohol use and stated asking R2 about his drinking triggers could be a trigger itself. Staff were to monitor R2 for signs/symptoms of substance use, and R2 was not willing to share his triggers with the facility. The team verified R2's records did not indicate his target behaviors or non-pharmacological interventions for behaviors. The team stated they have a PIP (Personal improvement plan) to look at psychotropic medications, target behaviors, and nonpharmacological interventions. The management team expected staff to notify them immediately of events such as the one which occurred between R1 and R2 on 6/10/26, because immediate follow-up for residents was important to promote the best possible psychosocial wellbeing. R1's Mood and Behavior Review assessment dated 2/18/26, identified R1 used antipsychotic and antidepressant medication. R1 had verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others. The assessment did not fill in the area to indicate review of current target behaviors and resident specific interventions. The assessment indicated redirection was generally effective for R1's mood and behaviors. R1's Care Conference Summary Resident Profile dated 5/21/26, identified a care conference occurred on 6/3/26 and Community Life section was not filled in. The Care Conference Summary's signature and date section was blank. The facility did not provide activity tracking for R1 from the community of life team.			F0740			08/03/2026

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F0740 SS = D	Continued from page 14 The facility did not provide a recent care conference summary for R2 or activity tracking for R2 from the community of life team. The facility Behavioral Health Services policy dated 4/1/26, indicated a resident care plan will have person-centered, evidence-based, trauma-informed interventions. The policy directed the facility to provide meaningful activities to promote engagement and positive, meaningful relationships. The policy directed the facility to review and revise the care plan as needed, such as when interventions were not effective or when the resident experienced a change of condition.			F0740			08/03/2026

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/24/26, 6/25/26, 6/29/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with MN State Licensure. The following complaints were reviewed: H52712888C (3040661). NO licensing orders were issued. Minnesota Department of Health is documenting the			20000			07/23/2026

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 State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			20000			07/23/2026

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